(17)

No. 97-303-CFX Title: Humana Inc., et al., Petitioners
v.
Mary Forsyth, et al.

Docketed: August 18, 1997 Court: United States Court of Appeals for the Ninth Circuit

Entry	Date	Proceedings and Orders
	Aug 18 1997	Petition for writ of certiorari filed. (Response due September 17, 1997)
	Sep 16 1997	Brief of respondents Mary Forsyth, et al. in opposition filed.
	Sep 26 1997	Reply brief of petitioners Humana, Inc., et al. filed.
	Nov 5 1997	DISTRIBUTED. November 26, 1997
	Dec 1 1997	The Solicitor General is invited to file a brief in this case expressing the views of the United States.
	May 29 1998	Brief amicus curiae of United States filed.
	Jun 2 1998	REDISTRIBUTED. June 18, 1998
	Jun 22 1998	Petition GRANTED. SET FOR ARGUMENT November 30, 1998. **********
	Aug 6 1998	Brief of petitioners Humana Inc. and Humana Health Insurance of Nevada, Inc. filed.
	Aug 6 1998	Joint appendix filed.
	Aug 6 1998	Motion of Alliance of American Insurers, et al. for leave to file a brief as amici curiae filed.
	Aug 11 1998	Motion of Consumer Credit Insurance Association for leave to file a brief as amicus curiae filed.
	Aug 24 1998	Order extending time to file brief of respondent on the merits until September 18, 1998.
	Sep 9 1998	Motion of Alliance of American Insurers, et al. for leave to file a brief as amici curiae GRANTED.
	Sep 9 1998	Motion of Consumer Credit Insurance Association for leave to file a brief as amicus curiae GRANTED.
	Sep 18 1998	Brief amicus curiae of United States filed.
	Sep 18 1998	Brief amicus curiae of National Fair Housing Alliance filed.
	Sep 18 1998	Brief amicus curiae of United Policyholders filed.
	Sep 18 1998	Brief of respondents Mary Forsyth, et al. filed.
	Sep 18 1998	Brief amici curiae of Betty Cordial, Arnold Dutcher and Barry Hittner filed.
	Sep 18 1998	LODGING consisting of ten copies each of cases cited by counsel for Betty Cordial, et al.
	Sep 18 1998	Brief amicus curiae of National Association of Insurance Commissioners filed.
	Sep 18 1998	Brief amicus curiae of Trial Lawyers for Public Justice filed.
	Sep 23 1998	Record filed.
	Sep 30 1998	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Oct 13 1998	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Oct 16 1998	Application (A98-306) to extend the time to file a reply

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No. 97-303-CFX

Entry	Date	Proceedings and Orders
		brief from October 19, 1998 to October 23, 1998, submitted to Justice O'Connor.
	Oct 16 1998	Application (A98-306) granted by Justice O'Connor extending the time to file until October 23, 1998.
	Oct 23 1998	Reply brief of petitioners Humana Inc., et al. filed.
	Oct 28 1998	CIRCULATED.
	Nov 30 1998	ARGUED.
	Dec 14 1998	Record filed.

Supreme Court, U.S.
FILED

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No. _____ OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

HUMANA INC., and
HUMANA HEALTH INSURANCE OF NEVADA, INC.,
Petitioners,

v.

MARY FORSYTH, MARIETTA CADE,
WILLIE ANDREWS, MARY LOU BUEHLER,
HELEN STAVES, RANDOLPH BRATTON,
AND SEARLE AUTO GLASS, INC.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the application of a federal statute -- here the Racketeer Influenced and Corrupt Organizations Act ("RICO") -- to the business of insurance would "invalidate, impair or supersede" state law regulating the same conduct in contravention of the McCarran-Ferguson Act where the state and federal statutory prohibitions are parallel, but the remedies provided are materially different.

PARTIES TO THE PROCEEDING BELOW

1. Humana Inc. ("Humana") and Humana Health Insurance of Nevada, Inc. ("Humana Insurance"), petitioners herein, were defendants in the district court and appellees in the court of appeals. Humana Insurance is a wholly owned subsidiary of Humana. There are no other parent corporations of petitioners and no nonwholly owned subsidiaries; but, by reason of certain contractual obligations undertaken in connection with the acquisition of Humana's former hospital operations subsequent to the events at issue herein, Columbia/HCA Healthcare Corporation is beneficially interested in the outcome of this litigation.

2. Mary Forsyth, Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc., respondents here, were plaintiffs in the district court and appellants in the court of appeals. They were certified by the district court pursuant to Rule 23 of the Federal Rules of Civil Procedure as representatives of the classes described herein.

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In The

SUPREME COURT OF THE UNITED STATES

October Term, 1996

Humana Inc., and
Humana Health Insurance of Nevada, Inc.,
Petitioners,

v.

Mary Forsyth, Marietta Cade,
Willie Andrews, Mary Lou Buehler,
Helen Staves, Randolph Bratton,
and Searle Auto Glass, Inc.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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PETITION FOR WRIT OF CERTIORARI

REPORT OF OPINIONS BELOW

The opinion of the court of appeals is reported as *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997). That opinion withdraws and supersedes an earlier opinion of the same court reported as *Forsyth v. Humana, Inc.*, 99 F.3d 1504 (9th Cir. 1996). The opinion of the district court is reported as *Forsyth v. Humana, Inc.*, 827 F. Supp. 1498 (D. Nev. 1993). The decisions of the court of appeals and the

district court are found as Appendices A and B hereto respectively.

JURISDICTION

The decision for which review is sought was entered by the court of appeals on May 23, 1997. That decision granted in part a timely motion for rehearing filed by petitioners here respecting an earlier decision entered by the court of appeals on November 5, 1996. This Court has jurisdiction to review the decision at issue by writ of certiorari pursuant to 28 U.S.C. §§ 1254(1) and 2101(c).

STATUTES AT ISSUE

This petition addresses principally the interpretation of section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), which provides, in pertinent part:

> "No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."

The civil remedy provisions of RICO, 18 U.S.C. §§ 1961-1968 are also implicated by this petition. The full texts of all pertinent statutory provisions are set forth in Appendix C hereto.

STATEMENT OF THE CASE

A. Jurisdiction Below.

The district court had jurisdiction pursuant to 28 U.S.C. § 1331.

B. Pertinent Facts and Procedural History.

This action arises out of disputes respecting the administration and interpretation of employee group health insurance policies sold by Humana Insurance in the mid-1980's in the State of Nevada. These policies contained a "co-payment" provision pursuant to which patients covered by the policies were obligated to pay all charges up to a specified deductible and to pay 20% of charges above the deductible (up to a specified annual maximum). Humana Insurance was responsible for the remaining 80%.

Among other coverages, the policies covered treatment at certain Nevada hospitals, including a hospital owned by Humana, Humana Hospital-Sunrise ("Sunrise"). Humana Insurance negotiated discounts with Sunrise for hospital services provided to its policy beneficiaries, substantially reducing the costs on many procedures. In administering the co-payment feature of the policies, Humana Insurance applied those discounts to its 80% obligation. Policy beneficiaries continued to be billed for their 20% of the undiscounted hospital charge.

On this nucleus of facts, plaintiffs have asserted three claims for relief: (1) a claim under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*; (2) a claim under the Sherman Act, 15 U.S.C. § 1 *et seq.*; and (3) a RICO claim. These claims are urged on behalf of two classes certified by the district court -- a class of the employers who bought the policies (the "Premium Payor Class") and a class of the employees who made co-payments under the policies (the "Co-Payor Class").

The opinions below address all three claims,[1] but only the RICO claim is at issue here.

The RICO claim is predicated upon the allegation (denied by petitioners and not yet tried below) that Humana Insurance concealed or misrepresented its discount arrangements with Sunrise in various mailings, telephone calls and television or radio advertisements directed at both classes. The purpose of these alleged acts of mail and wire fraud, according to plaintiffs, was to defraud the employer members of the Premium Payor Class into purchasing the policies and to defraud the employee members of the Co-Payor Class into making excessive co-payments. Humana and Humana Insurance moved the district court for summary judgment on this RICO claim on the grounds, *inter alia*, that the application of RICO to the insurance practices at issue was barred by section 2 of the McCarran-Ferguson Act.

The district court held that RICO was subject to the limitations of the McCarran-Ferguson Act, that the conduct alleged was part of the business of insurance and that the conduct was subject to Nevada's comprehensive regulatory

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[1] The district court granted summary judgment on all claims. The Ninth Circuit affirmed the district court's grant of summary judgment on the ERISA claim and reversed the grant of summary judgment on the Sherman Act claim. While petitioners believe that the latter ruling was erroneous, they do not urge that the issue as currently framed by the Ninth Circuit decision satisfies the criteria for review set forth in this Court's Rule 10.

scheme governing the business of insurance in that state which reserves to the Nevada Commissioner of Insurance "exclusive jurisdiction" in regulating the trade practices of the insurance industry. Appendix B at 91a-97a. (827 F. Supp. at 1520-21.) The district court also concluded that application of RICO to those practices would impair Nevada's regulatory scheme because RICO's civil penalties -- principally its treble damages provision -- far exceed the penalties proscribed by the State of Nevada for the same conduct: "For this Court to allow Plaintiffs to pursue the harsher RICO penalties for behavior which the Nevada Legislature apparently did not deem worthy of such penalties, would be tantamount to allowing Congress to intercede in an area expressly left to the states under the McCarran-Ferguson Act." Appendix B at 95a. (827 F.Supp. at 1521-22.) On this reasoning, the district court granted summary judgment on the RICO claim.[2]

On appeal, the Ninth Circuit reversed the district court on this issue. The court of appeals agreed with the district court's determination that the conduct at issue was the business of insurance, that Nevada regulated the conduct and that RICO was subject to the limitations of the McCarran-

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[2] The district court also granted summary judgment on the RICO claim as to the Premium Payor Class on the alternative ground that the members of that class could not show a causal nexus between the alleged predicate acts and the damages claimed. Appendix B at 86a-90a. (827 F.Supp. at 1518-20.) This ruling was affirmed by the Ninth Circuit. Appendix A at 26a-28a. (114 F.3d at 1481-82.)

Ferguson Act. Appendix A at 22a-25a. (114 F.3d at 1479-80.) The court of appeals did not agree, however, that the application of RICO would impair Nevada's regulatory scheme. Relying upon its recent decision in *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486 (9th Cir.), *cert. denied* __ U.S. __, 116 S.Ct. 418 (1995), the court of appeals held that the disparity in remedies between RICO and Nevada insurance law did not create a conflict between federal and state law sufficient to preclude plaintiffs' RICO claim. Appendix A at 25a-26a. (114 F.3d at 1480.)

REASONS FOR GRANTING THE WRIT

Review by this Court is necessary to resolve a conflict between the circuits on the question presented by this petition. As noted, the Ninth Circuit has concluded that the McCarran-Ferguson Act does not preclude the application of federal law to the business of insurance where the federal and state statutes are parallel in their prohibitions, even though the consequences of violation of the federal statute are materially greater than those for violation of the state statute. The Sixth and Eighth Circuits have reached precisely the opposite conclusion, with both holding, as the district court did here, that application of the treble damages remedy allowed by RICO would conflict with the decision of the state legislatures to impose lesser penalties and, hence, impair the state regulatory scheme. *Doe v. Norwest Bank Minnesota*, 107 F.3d 1297, 1306-08 (8th Cir. 1997); *Kenty v. Bank One, Columbus N.A.*, 92 F.3d 384, 392-93 (6th Cir. 1996). In addition, although it has published no opinion explaining its reasoning, the Fourth Circuit has upheld a

district court ruling that the McCarran-Ferguson Act bars application of RICO to the business of insurance, affirming *per curiam* a decision to that effect in the Eastern District of Virginia. *Ambrose v. Blue Cross & Blue Shield*, 891 F. Supp. 1153, 1165-68 (E.D. Va. 1995), *aff'd mem.*, 95 F.3d 41 (4th Cir. 1996).[3]

The Ninth Circuit is alone among the Circuits in holding that RICO's remedies do not create a conflict with less draconian state laws. The Sixth and Seventh Circuits have, however, upheld the application of federal statutes whose remedies differ less significantly than do RICO's from the state laws that they parallel. *Nationwide Mut. Ins. Co. v. Cisneros*, 52 F.3d 1351, 1363 (6th Cir. 1995), *cert. denied*, __ U.S. __, 116 S.Ct. 973 (1996) (Fair Housing Act);[4] *NAACP v. American Family Mut. Ins. Co.*, 978 F.2d 287, 295-97 (7th Cir. 1992), *cert. denied*, 508 U.S. 907 (1993) (Fair Housing Act).

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[3] District court decisions to the same effect may also be found in the Third Circuit. *Wexco Inc. v. INC, Inc.*, 820 F. Supp. 194, 203-06 (N.D. Pa. 1993); *Senich v. Transamerica Premier Ins. Co.*, 766 F. Supp. 339, 341-42 (W.D. Pa. 1990).

[4] In *Kenty v. Bank One*, *supra*, 92 F.3d at 392, the Sixth Circuit distinguished its holding there that the McCarran-Ferguson Act bars the application of RICO from its earlier decision in *Cisneros* respecting the Fair Housing Act by noting that the differences between that statute and the parallel state law were principally procedural -- *i.e.*, the availability *vel non* of trial by jury -- rather than substantive.

The disparity among the treatments afforded to this issue by the circuits reflects the paucity of guidance to be found in the prior decisions of this Court. As the Eighth Circuit noted in *Doe v. Norwest Bank*, *supra*, 107 F.3d at 1307, this Court has addressed the question of the degree of conflict necessary to trigger the McCarran-Ferguson Act only in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), and that decision involved federal and state statutes intended to protect entirely different interests.[5] The issue here presented has never been addressed by this Court.

The need for further guidance from this Court is apparent. The fact that four circuits have had to address the relationship between RICO and McCarran-Ferguson in the last two years itself attests to the significance of the question. It is also a clear predictor of the direction that future litigation will take in circuits that adopt the views of the Ninth Circuit. The attractiveness of RICO's remedies will assure that an ever increasing volume of insurance litigation will find its way to federal court for decision under federal law. Moreover, the issue presented is of broader reach than the specific question of whether McCarran-Ferguson precludes RICO claims. At issue is the question of whether the remedies provided by state laws regulating insurance are to be viewed as part of the substantive law of the state so as to preclude the application of *any* federal statute providing materially different remedies for the same conduct.

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[5] The First Circuit found a similar difference in the intended protections of Puerto Rican insurance law and the Federal Deposit Insurance Act. *Villafane-Neriz v. FDIC*, 75 F.3d 727, 736 (1st Cir. 1996).

That resolution of this issue should favor the Eighth, Sixth and Fourth Circuits, and not the Ninth Circuit's approach, is well argued in the Eighth Circuit's recent decision:

> "We find the latter line of cases more persuasive in the RICO context. As one court has noted, 'the remedies available under RICO are among the most severe ever enacted in a federal civil statute.' The state of Minnesota has determined that its insurance market can best be regulated by the Commissioner's pursuit of fines and injunctive relief. Congress has expressed its intention to leave the regulation of the business of insurance to the states unless a federal statute expressly addresses that subject or the application of a general federal statute would not invalidate, supersede, or impair a state statute. Were the question presented here, we might agree with the Sixth and Seventh Circuits that the federal civil rights statutes do not impair state insurance regulation. But Voyager [the insurance company defendant] makes a compelling case that the extraordinary remedies of RICO would frustrate, and perhaps even supplant, Minnesota's carefully developed scheme of regulation. We do not read the term 'impair' so narrowly as to permit the conclusion that the McCarran-Ferguson Act does not apply in the circumstances presented here." (Citations and footnote omitted.)

CONCLUSION

For the foregoing reasons, this petition for writ of certiorari should be granted.

August 18, 1997

Respectfully submitted

JAMES W. COLBERT, III
O'MELVENY & MYERS LLP

Counsel of Record for
Petitioners

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 94-16548

Opinion of the Court of Appeals for the Ninth Circuit

(Decided May 23, 1997)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTEN; and SEARLE AUTO GLASS, INC., d/b/a Best Glass Company,
Plaintiffs-Appellants,

v.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,
Defendants-Appellees.

May 23, 1997

Will Kemp, J. Randall Jones, Harrison, Kemp & Jones, Chtd., Las Vegas, NV, W.B. Markovits, Markovits & Greiwe, Cincinnati, Ohio, for the plaintiffs-appellants.

David N. Frederick, Las Vegas, Nevada and Robert N. Eccles, O'Melveny & Myers,

Washington D.C., for the defendants-appellees.

JUDGES: Before: J. Clifford Wallace and David R. Thompson, Circuit Judges, and Gordon Thompson, Jr., District Judge. * Opinion by Judge D. Thompson; Partial Concurrence and Partial Dissent by Judge Wallace.

* The Honorable Gordon Thompson, Jr., United States District Court Judge for the Southern District of California, sitting by designation.

THOMPSON, Circuit Judge:

There are two groups of plaintiffs in this case: (1) the employer purchasers of group health insurance policies issued by Humana Health Insurance of Nevada (Premium Payors); and (2) the employee beneficiaries of those policies who made coinsurance payments for health care received (Co-Payors).

The Co-Payors received hospital care from Humana Hospital-Sunrise (Sunrise Hospital), an acute care facility which is owned and operated by defendant Humana, Inc. Under its insurance agreements with the Co-Payors, Humana Health Insurance of Nevada (Humana Insurance) was obligated to pay 80% of the employees' hospital charges over and above a designated deductible amount; the Co-Payors were to pay the remaining 20%. Unknown to the plaintiffs, Humana Insurance negotiated a discount with Sunrise Hospital. Because of this discount, Humana Insurance ultimately paid significantly less than its 80% share of Sunrise Hospital's charges and the Co-Payors paid significantly more than their 20% co-payment share.

The Co-Payors contend Humana Insurance breached its contract with them, and violated the Employee Retirement

Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.*, by failing to pass along to them the Sunrise Hospital discounts in the form of reduced co-payments. The Co-Payors also contend the defendants violated ERISA by breaching fiduciary duties, engaging in prohibited transactions, and retaining excessive compensation. Both groups of plaintiffs contend that the defendants violated section 2 of the Sherman Act, 15 U.S.C. § 2, and engaged in a scheme to defraud in violation of the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961-1968.

The district court granted summary judgment in favor of the defendants, rejecting all of the plaintiffs' claims except the Co-Payors' ERISA benefits breach of contract claim. This appeal followed.

We have jurisdiction under 28 U.S.C. § 1291. We affirm the district court's summary judgment on the ERISA claims, reverse the district court's summary judgment on the Sherman Act antitrust claims, and affirm in part and reverse in part summary judgment on the RICO claims.

I

FACTS

The plaintiffs contracted for health insurance, through employee benefit plans, with Humana Insurance during the period of 1985 through 1988. Pursuant to an agreement made in 1984 between Humana Insurance and Sunrise Hospital, Humana Insurance would receive a discount for its portion of the hospital charges incurred by its insureds. Unaware of this discount, the plaintiffs continued to pay

their required premiums and undiscounted co-payments. As a result, Humana Insurance ended up paying less than 80% of the hospital's charges for health care services, the Co-Payors paid more than 20% of these charges, and the Premium Payors paid the same premiums despite the reduced cost to Humana Insurance of the health care services.

The plaintiffs assert that Humana Insurance concealed the discount deal by writing checks to Sunrise Hospital for 80% of the billed charges. Sunrise Hospital would then remit the clandestine discount to Humana Insurance through monthly intercompany transfers, in what the plaintiffs characterize as a "classic kickback scheme."

II

PROCEDURAL HISTORY

The plaintiffs filed this action in the district court on March 29, 1989, alleging both state and federal claims. Six months later, the court granted the defendants' motion, pursuant to Federal Rule of Civil Procedure 12(b)(6), to dismiss the state law claims because those claims were preempted by ERISA.

The plaintiffs filed a first amended complaint on October 27, 1989. Following another round of motions, the district court upheld the sufficiency of the plaintiffs' ERISA claims, some of the RICO claims and the antitrust claims, and certified the two classes of plaintiffs, Premium Payors and Co-Payors. At the district court's direction, the plaintiffs filed a second amended complaint.

The second amended complaint asserted three claims for relief: (1) an ERISA claim by the Co-Payor class against Humana Insurance alleging breach of fiduciary duty, prohibited transactions and retention of excessive compensation; (2) an antitrust claim under section 2 of the Sherman Act by both classes of plaintiffs alleging the defendants had monopolized or attempted to monopolize the market for acute care facilities in Clark County, Nevada; and (3) a RICO claim by both classes of plaintiffs alleging Humana Insurance marketed and administered its policies through repeated acts of mail and wire fraud.

Again, the defendants moved for summary judgment. On July 21, 1993, after exhaustive briefing and argument, the district court granted the motion in its entirety ("the July 21, 1993 judgment"), but gave the plaintiffs leave to file a third amended complaint to assert on behalf of the Co-Payor class an ERISA benefits breach of contract claim against Humana Insurance under 29 U.S.C. § 1132(a)(1)(B).

The plaintiffs filed a third amended complaint. In that complaint they asserted only one claim, a breach of contract claim under ERISA in which they alleged that the Co-Payor class was entitled to benefits under 29 U.S.C. § 1132(a)(1)(B), because Humana Insurance had not properly allocated the discount it received from Sunrise Hospital.

The Co-Payor class moved for summary judgment on this claim; Humana Insurance also moved for summary judgment as to the proper measure of damages. The district court granted both motions on June 3, 1994 (the "June 3, 1994 judgment"), finding liability on the breach of contract claim, but limiting damages to the excess charges the

Co-Payor plaintiffs paid, and specifying the methodology for calculating the damages for these class members. Following further submissions by the parties, the district court entered an order on July 29, 1994 approving and adopting a schedule of damage awards by which the Co-Payors were to be reimbursed the amounts they had been overcharged on their co-payments.

On July 1, 1994, before the district court determined the damage awards, the plaintiffs filed a notice of appeal from the district court's June 3, 1994 judgment. The plaintiffs voluntarily dismissed that appeal after we determined that the June 3, 1994 judgment was not a final, appealable order. Thereafter, the plaintiffs filed a timely notice of appeal which brings this case before us.

The defendants have moved to dismiss this appeal in its entirety, or in the alternative to limit the appeal to the sole claim asserted in the plaintiffs' third amended complaint. In the defendants' words, their motion to dismiss raises two jurisdictional issues: "(1) whether plaintiffs' voluntary dismissal of an earlier appeal from the June 3[, 1994] Judgment precludes review of that judgment here; and (2) whether plaintiffs' failure to preserve in their Third Amended Complaint claims dismissed by the district court's earlier Order of July 21, 1993, precludes review of that ruling in this appeal."

On the merits, the defendants dispute the plaintiffs' various claims of error, and ask us to affirm the district court across the board. We first consider the motion to dismiss or limit the appeal.

III

MOTION TO DISMISS OR LIMIT APPEAL

The plaintiffs' voluntary dismissal of their premature appeal from the June 3, 1994 judgment does not preclude review of that judgment in this appeal. The June 3, 1994 judgment was not a final, appealable order when it was entered because the district court had not then determined the amount of damages. *See Brown v. United States Postal Serv.*, 862 F.2d 884, 886 (9th Cir. 1988). We deny the motion to dismiss the appeal in its entirety.

The defendants' contention that the appeal should be limited to the ERISA benefits breach of contract claim asserted in the third amended complaint presents a more complicated question. The plaintiffs did not reallege in that complaint any of the claims previously dismissed by the district court. The question is whether this omission precludes our review of the district court's dismissal of the previously asserted claims.

It is the law of this circuit that a plaintiff waives all claims alleged in a dismissed complaint which are not realleged in an amended complaint. *London v. Coopers & Lybrand*, 644 F.2d 811, 814 (9th Cir. 1981); *Sacramento Coca-Cola Bottling Co. v. Chauffeurs, Teamsters and Helpers Local 150*, 440 F.2d 1096, 1098 (9th Cir.), *cert. denied*, 404 U.S. 826, 30 L. Ed. 2d 54, 92 S. Ct. 57 (1971); *Loux v. Rhay*, 375 F.2d 55, 57 (9th Cir. 1967). This rule is premised on the notion that the "amended complaint supersedes the original, the latter being treated thereafter as non-existent." *Loux*, 375 F.2d at 57. If a plaintiff fails to

include dismissed claims in an amended complaint, the plaintiff is deemed to have waived any error in the ruling dismissing the prior complaint. *London*, 644 F.2d at 814; *Sacramento Coca-Cola*, 440 F.2d at 1098; *Loux*, 375 F.2d at 57.

We have declined, however, to extend the London rule to amended complaints that follow summary judgment. *See USS-POSCO Indust. v. Contra Costa County Bldg. & Const. Trades Council*, 31 F.3d 800, 812 (9th Cir. 1994). The rulings challenged by the plaintiffs in this appeal are rulings on summary judgment. As such, the claims which the court dismissed pursuant to these rulings have not been waived by the plaintiffs' failure to reallege them in the third amended complaint. *Id.* The defendants' motion to limit the issues in this appeal to the claim asserted in the plaintiffs' third amended complaint is therefore denied. To the extent, however, that the plaintiffs seek review of the district court's earlier dismissal of their state law claims pursuant to Federal Rule of Civil Procedure 12(b)(6), such claims were waived by the failure to reallege them after the Rule 12(b)(6) dismissal. *London*, 644 F.2d at 814.

IV

MERITS

A. Standard of Review

We review a grant of summary judgment de novo. *Warren v. City of Carlsbad*, 58 F.3d 439, 441 (9th Cir. 1995), *cert. denied*, 134 L. Ed. 2d 209, 116 S. Ct. 1261 (1996). We must determine, viewing the evidence in the light most favorable to the nonmoving party, whether there

are any genuine issues of material fact and whether the district court correctly applied the relevant substantive law. *Id.*

B. ERISA

The district court concluded the Co-Payor plaintiff class had no standing to bring their ERISA claim under 29 U.S.C. § 1132(a)(3) for breach of fiduciary duty. The court determined that the remedy provided by ERISA for the Co-Payors' harm was a benefits claim for breach of contract pursuant to section 1132(a)(1)(B) and not a claim for breach of fiduciary duty under section 1132(a)(3).

While this appeal was pending the Supreme Court issued its decision in *Varity Corp. v. Howe*, 134 L. Ed. 2d 130, 116 S. Ct. 1065 (1996). The Court held that an individual beneficiary may bring suit against a plan administrator for a breach of fiduciary duty under 29 U.S.C. § 1132(a)(3). Previous case law in this circuit had allowed such an action only in very limited circumstances not present in this case. *See, e.g., Amalgamated Clothing & Textile Workers Union v. Murdock*, 861 F.2d 1406 (9th Cir. 1988); *Waller v. Blue Cross of California*, 32 F.3d 1337 (9th Cir. 1994). The opinion in *Varity Corp.* expands what we previously viewed as permissible actions under section 1132(a)(3), but not to the extent necessary to accommodate the Co-Payors' claim in this case.

In *Varity Corp.* the Court emphasized that section 1132(a)(3) is a "catchall" provision which provides relief only for injuries that are not otherwise adequately provided for. 116 S. Ct. at 1078.

> Thus, we should expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be "appropriate."

The Supreme Court thus interpreted the statute to allow individual relief for a breach of fiduciary duty in an ERISA action only where no other adequate relief is available.

The Court distinguished *Massachusetts Mut. Life Ins. v. Russell*, 473 U.S. 134, 144, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985), which had interpreted section 1132(a)(2) to allow recovery for breach of fiduciary duty only where the relief is sought on behalf of the entire plan. Other than the fact that it had interpreted a different subsection of the statute, one of the factors which distinguished *Russell* was that another remedy, section 1132(a)(1), already provided specific relief for the sort of injury suffered in that case.

In the present case, the Co-Payors seek to recover individual relief under section 1132(a)(3) for Humana Insurance's breach of fiduciary duty. But the Co-Payors have already won a judgment for damages under section 1132(a)(1) for the injuries they suffered as a result of the defendant's actions. The district court determined, and we agree, that the Co-Payors are entitled to recover, in the form of damages pursuant to their claim under section 1132(a)(1), all amounts they were forced to pay over and above their contractual co-payment obligation.

In these circumstances, *Varity Corp.* does not authorize equitable relief under the catchall provision of section

1132(a)(3). Equitable relief under section 1132(a)(3) is not "appropriate" because section 1132(a)(1) provides an adequate remedy in this case.

We affirm the district court's summary judgment against the Co-Payors on their breach of fiduciary duty claim under section 1132(a)(3) of ERISA. We also affirm the district court's summary judgment in favor of the Co-Payors on their benefits breach of contract claim under section 1132(a)(1) of ERISA and the district court's computation of damages set forth in its July 29, 1994 order.

C. Antitrust

The plaintiffs sought approximately $ 181 million in damages against the defendants for monopolization and attempted monopolization under section 2 of the Sherman Act, 15 U.S.C. § 2.[1] The district court concluded the plaintiffs failed to produce evidence in support of this claim sufficient to survive a motion for summary judgment. Specifically, the district court determined the plaintiffs had

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[1] Title 15 U.S.C. @ 2 provides:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $ 10,000,000 if a corporation, or, if any other person, $ 350,000, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

not provided sufficient evidence in support of their claim of monopolization to establish the relevant submarkets they asserted, the exercise of market power, or antitrust injury.

To prevail on a claim of monopolization under section 2 of the Sherman Act, a plaintiff must demonstrate: "(1) possession of monopoly power in the relevant submarket; (2) willful acquisition or maintenance of that power; and (3) causal antitrust injury." *Pacific Express, Inc. v. United Airlines*, Inc., 959 F.2d 814, 817 (9th Cir.), *cert. denied*, 506 U.S. 1034, 121 L. Ed. 2d 686, 113 S. Ct. 814 (1992).

Monopoly power, for the purpose of section 2 of the Sherman Act, is "the power to control prices or exclude competition." *United States v. Grinnell Corp.*, 384 U.S. 563, 571, 16 L. Ed. 2d 778, 86 S. Ct. 1698 (1966) (quoting *United States v. E. I. du Pont de Nemours & Co.*, 351 U.S. 377, 391, 100 L. Ed. 1264, 76 S. Ct. 994 (1956)). A plaintiff may demonstrate market power either by direct evidence or by circumstantial evidence. *Rebel Oil Co. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1434 (9th Cir.), *cert. denied*, 133 L. Ed. 2d 424, 116 S. Ct. 515 (1995). Direct proof of market power may be shown by evidence of restricted output and supracompetitive prices. *Id.* Such a showing "is direct proof of the injury to competition which a competitor with market power may inflict, and thus, of the actual exercise of market power." *Id.*

The plaintiffs submitted evidence that Sunrise Hospital routinely charged higher prices than other hospitals while reaping high profits. With no accompanying showing of restricted output, however, the plaintiffs have failed to present direct evidence of market power.

The more common method of establishing monopoly power is by circumstantial evidence. This requires the plaintiff to "(1) define the relevant market, (2) show that the defendant owns a dominant share of that market, and (3) show that there are significant barriers to entry and show that existing competitors lack the capacity to increase their output in the short run."

It is impossible to determine market share without first defining the relevant market. *Id.* at 1434. Definition of the relevant market cannot be performed with mathematical accuracy; it is simply the recognition of a field in which meaningful competition is said to exist. *See United States v. Continental Can Co.*, 378 U.S. 441, 449, 12 L. Ed. 2d 953, 84 S. Ct. 1738 (1964). We have previously defined the relevant market as the group of sellers or producers who have the "actual or potential ability to deprive each other of significant levels of business." *Thurman Indus., Inc. v. Pay 'N Pak Stores, Inc.*, 875 F.2d 1369, 1374 (9th Cir. 1989). "The definition of the relevant market is a factual inquiry for the jury, and the court may not weigh evidence or judge witness credibility." *Rebel Oil*, 51 F.3d at 1435. *See also Thurman Indus.*, 875 F.2d at 1374.

The district court held the relevant market was the general acute care hospital market in Clark County, Nevada, which consisted of seven facilities in addition to Sunrise Hospital. The plaintiffs contend the district court arrived at this conclusion by weighing competing evidence. The plaintiffs argue the relevant market is smaller than the market found by the district court. They contend there are two distinct submarkets which the defendants monopolized

or attempted to monopolize: (1) the acute care hospitals actually used by Humana insureds; and (2) the major for-profit acute care hospitals in Clark County, Nevada. "A submarket exists if it is sufficiently insulated from the larger market so that supply and demand are inelastic with the larger market." *Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.*, 924 F.2d 1484, 1490 (9th Cir. 1991).

In support of their first contention that the relevant submarket is the acute care hospitals actually used by Humana insureds, the plaintiffs submitted an affidavit indicating that 75% to 85% of Humana insureds used Sunrise Hospital, and that this high proportion was achieved through contractual disincentives such as higher deductibles and co-payments for other hospitals, and noncontractual disincentives such as delaying or denying payment to other hospitals which made it difficult for Co-Payors touse them.

We reject the plaintiffs' attempt to limit the relevant market to acute care hospitals used by Humana insureds. The plaintiffs used Sunrise Hospital and obtained medical care from few other hospitals because of contractual provisions in their insurance policies. This tie-in defeats the plaintiffs' argument for a submarket consisting only of those hospitals Humana insureds actually used. *See Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 490-91, 119 L. Ed. 2d 265, 112 S. Ct. 2072 (Scalia, J., dissenting) (1992). To succeed in the face of the contractual tie-in created by the insurance policies, the plaintiffs would have to make a showing of monopoly power in the health insurance market, and there is no evidence of this. *See id.*;

Jefferson Parish Hosp. Dist. 2 v. Hyde, 466 U.S. 2, 13-14, 80 L. Ed. 2d 2, 104 S. Ct. 1551 (1984).

The plaintiffs' second asserted relevant submarket consists of the major for-profit acute care hospitals in Clark County, Nevada. This submarket allegedly includes Sunrise Hospital, Valley Hospital, and Desert Springs Hospital. Excluded from this market are Clark County's five remaining acute care hospitals, Boulder City Hospital (Boulder City), Community Hospital of North Las Vegas (Community), St. Rose De Lima Hospital (St. Rose), University Medical Center (UMC), and Women's Hospital (Women's). The plaintiffs submitted evidence tending to support their contention that the five remaining acute-care hospitals in Clark County, which the district court included in its determination of the relevant market, were not competitors of Sunrise Hospital. For example, there was evidence that UMC charged patients 15 to 20 percent less than Sunrise Hospital. Yet, because UMC was considered a hospital for the indigent, patients with a choice, such as those with insurance, eschewed UMC in favor of the larger for-profit hospitals despite the significantly lower price at UMC.

We recognize "the scope of the relevant market is not governed by the presence of a price differential." *Twin City Sportserv., Inc. v. Charles O. Finley & Co.*, 512 F.2d 1264, 1274 (9th Cir. 1975). But when demand for the commodity of one producer shows no relation to the price for the commodity of another producer, it supports the claim that the two commodities are not in the same relevant market.

There was also evidence that Boulder City, St. Rose, Community, and Women's were considered "niche" hospitals that did not offer the range of services available at Sunrise Hospital. This, alone, is not enough. Specialty shops which offer only a limited range of goods are generally considered in the same market with larger, more diverse, "one-stop shopping" centers. *Thurman Indust.*, 875 F.2d at 1374-77. However, the plaintiffs also submitted documentary evidence, including an expert's affidavit and testimony before the Nevada legislature, which tended to support their contention that these specialty hospitals did not, in fact, compete with Sunrise Hospital.

We have not recounted the evidence submitted by the defendants, but it was substantial. Were we to weigh the evidence we might be inclined to find that the plaintiffs failed to establish their alleged submarket. On a motion for summary judgment, however, this would be inappropriate.

We conclude the evidence the plaintiffs presented was sufficient to withstand the defendants' motion for summary judgment as to the plaintiffs' second asserted relevant market.

The additional issues of monopoly power and the maintenance of monopoly power depend upon a resolution of the relevant market question. *Rebel Oil*, 51 F.3d at 1434. Whether the defendants engaged in anticompetitive behavior is dependent upon resolution of these issues. *See Pacific Express*, 959 F.2d at 818.

The same may be said of the plaintiffs' section 2 claim for attempted monopolization. To prevail on such a claim, a

plaintiff must demonstrate four elements: (1) specific intent to control prices or destroy competition; (2) predatory or anticompetitive conduct directed toward accomplishing that purpose; (3) a dangerous probability of success; and (4) causal antitrust injury. *Rebel Oil*, 51 F.3d at 1433.

The plaintiffs' claim of attempted monopolization was not directly addressed by the district court. Resolution of this issue, like the claim of actual monopolization, is dependent upon a definition of the relevant market. Without such a determination, we cannot assess whether challenged activity was anticompetitive. In sum, the determination of all these subsidiary issues depends on the determination of the question of the relevant market; and there is a genuine dispute of material fact as to that.

The plaintiffs should also survive summary judgment on the issue of causal antitrust injury. To survive summary judgment, the plaintiffs were required to offer some evidence demonstrating "the existence of an 'antitrust injury, which is to say injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendant's acts unlawful.'" *Atlantic Richfield v. USA Petroleum*, 495 U.S. 328, 334, 109 L. Ed. 2d 333, 110 S. Ct. 1884 (1990) (quoting *Brunswick Corp. v. Pueblo Bowl-O-Mat*, 429 U.S. 477, 489, 50 L. Ed. 2d 701, 97 S. Ct. 690 (1977)).

Here, the plaintiffs presented evidence that, as a result of Humana's anticompetitive behavior, they paid higher copayments and premiums than they would have paid in a competitive market. This evidence, while it shows that the plaintiffs paid high copayments and premium payments because of the kickback scheme, does not explain how the

scheme reduced competition in the relevant market. We conclude, therefore, that the plaintiffs did not demonstrate that they suffered antitrust injury resulting from the kickback scheme. *See Atlantic Richfield*, 495 U.S. at 344 (observing that "the antitrust injury requirement ensures that a plaintiff can recover only if the loss stems from a competition-reducing aspect or effect of the defendant's behavior.").

The plaintiffs presented other evidence, however, that Humana engaged in impermissibly anticompetitive conduct in three ways: (a) Sunrise (the Humana-owned hospital) was the only area hospital certified to provide Level III neonatal care, but refused to provide Level III care under separate contract; (b) Sunrise diverted indigent or low-paying critical care patients to other area hospitals; and (c) Humana threatened physicians who did not support its monopoly.

This conduct describes antitrust violations. The plaintiffs presented evidence that Sunrise required customers who wanted to buy Level III neonatal care to also buy other neonatal services. Such a practice could constitute an anticompetitive tying arrangement. *See Datagate, Inc. v. Hewlett-Packard Co.*, 60 F.3d 1421, 1423 (9th Cir. 1995) (describing a tying arrangement as a "device used by a competitor with market power in one market . . . to extend its market power into an entirely distinct market."). Sunrise's alleged policy of funneling indigent and low-paying patients to competitors raises a factual question whether such conduct increased the operating cost of those competitors by imposing on them the cost of caring for indigent patients. *See Multistate Legal Studies, Inc. v. Harcourt Brace*

Jovanovich Legal and Professional Publications, Inc., 63 F.3d 1540, 1553 (10th Cir. 1995) (stating that monopolist's practice of scheduling courses to conflict with competitor's courses could raise competitor's costs, and therefore, "would qualify as anticompetitive conduct"); *Premier Electrical Constr. Co. v. Nat'l Electrical Contractors Ass'n*, 814 F.2d 358, 368 (7th Cir. 1987) (observing that, when defendant "raised its rivals' costs," it "raised the market price to its own advantage."); *see generally* T. Krattenmaker & S. Salop, Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price, 96 Yale L.J. 209, 235-262 (1986). Finally, the plaintiffs presented evidence that Humana's alleged practice of threatening physicians who disagreed with their monopoly limited competition by preventing physicians from referring patients to hospitals other than Sunrise. *See Potters Medical Center v. City Hospital Ass'n*, 800 F.2d 568, 575 (6th Cir. 1986) (holding that hospital's alleged conduct in restricting privileges of physicians "could state a monopolization claim.").

According to the plaintiffs' evidence, these anticompetitive practices enabled Sunrise to, and it did, charge higher prices for hospital services. These higher prices translated into higher copayments and premium payments. Such an increase in consumer prices caused by the asserted conduct would constitute antitrust injury of the type the antitrust laws were designed to prevent. *See Blue Shield of Virginia v. McCready*, 457 U.S. 465, 73 L. Ed. 2d 149, 102 S. Ct. 2540 (1982) (holding that individual health care plan subscriber could sue health care provider for antitrust injury resulting from provider's alleged boycott of psychologists); *Reiter v. Sonotone Corp.*, 442 U.S. 330,

341, 60 L. Ed. 2d 931, 99 S. Ct. 2326 (1979) (holding that consumers of retail goods and services have standing to sue under the antitrust laws when they suffer a price increase resulting from anticompetitive conduct).

We conclude, therefore, that the plaintiffs are entitled to survive summary judgment on the issue of antitrust injury. In calculating the plaintiffs' antitrust damages, the jury will be faced with the difficult task of separating the antitrust damages from the damages resulting from Humana's kickback scheme. Complex antitrust cases, however, invariably involve complicated questions of causation and damages. *See Potters Medical Center*, 800 F.2d at 576 (observing that speculative nature of damages are "often the case in complex antitrust litigation and should not in itself foreclose antitrust standing.").

We reverse the district court's summary judgment in favor of the defendants on the plaintiffs' antitrust claim.

D. RICO

Both the Premium Payor and the Co-Payor classes alleged that during the period from 1985 through 1988, in violation of the civil RICO statute, 18 U.S.C. § 1964(e):[2]

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[2] Title 18 U.S.C. @ 1964(c) provides:

Any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee.

(1) Humana, Inc. and Humana Insurance acted as members of an "association in fact" enterprise, or alternatively, that Humana, Inc., a person within the meaning of 18 U.S.C.§ 1961(3), associated with Humana Insurance, an enterprise within the meaning of 18 U.S.C. § 1961(4); (2) Humana Inc. and Humana Insurance entered into a secret agreement to give Humana Insurance an excessive discount for hospital charges incurred by its insureds; (3) Humana Inc. and Humana Insurance concealed and misrepresented this agreement in numerous mailings, television and radio commercials, and telephone calls; and (4) such acts were intended to defraud the Premium Payor class into purchasing policies and the Co-Payor class into paying excessive co-payments.

The district court granted the defendants' motion for summary judgment because it found the plaintiffs' RICO claims were barred by the McCarran-Ferguson Act. Additionally, the district court determined that the Premium Payors' RICO claim failed because the Premium Payors failed to demonstrate a direct relationship between the alleged injurious conduct and the injury asserted (excessive premiums), or any "'concrete financial injury,' for the purposes of RICO." The district court also held the defendants were "entitled to summary judgment on the Co-Payor class's RICO claim to the extent that the Co-Payor class [sought] damages in excess of the amount that could have been recovered under a proper interpretation of the co-payment provision."

1. The McCarran-Ferguson Act

The MFA, 15 U.S.C. § 1011, *et seq.*, was enacted, in part, to allow states to regulate the business of insurance free from inadvertent preemption by federal statutes of general applicability. *Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486, 1488-89 (9th Cir.), *cert. denied*, 116 S. Ct. 418, 133 L. Ed. 2d 335 (1995). Section 2(b) of the MFA provides in pertinent part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.

We have adopted a four-part test to determine when section 2(b) of the MFA precludes the application of a federal statute to preempt state insurance law. *Merchants Home*, 50 F.3d at 1489. The MFA precludes such preemption by a federal statute if: "(1) the statute does not 'specifically relate' to the business of insurance, (2) the acts challenged under the statute constitute the business of insurance, (3) the state has enacted a law or laws regulating the challenged acts, and (4) the state law would be superseded, impaired or invalidated by the application of the federal statute." *Id.* All four factors must be satisfied. *Id.* Only the first factor is not disputed in this case - the parties concede RICO does not specifically relate to the business of insurance.

With regard to the second factor, the crux of the plaintiffs' claim is that Humana Insurance misrepresented

how premiums would be calculated, leading the Premium Payors to believe a discount from Sunrise Hospital would lower their premium rates, and that the defendants overcharged the Co-Payors by billing them for 20% of the undiscounted cost of their hospital care.

The plaintiffs argue these allegedly fraudulent acts cannot be part of the business of insurance because "fraud is not a legitimate aspect of risk management." In *Merchants Home* we rejected such an argument and we do so again. It is useless "to point to a practice forbidden by federal law . . . and observe that this practice is not itself insurance." *Id.* at 1490 (quoting *NAACP v. American Family Mut. Ins. Co.*, 978 F.2d 287, 294 (7th Cir. 1992), *cert. denied*, 508 U.S. 907, 124 L. Ed. 2d 247, 113 S. Ct. 2335 (1993)). Such an interpretation would "read the McCarran-Ferguson Act out of existence" because "any practice which violated any federal statute would, by definition, not be the 'business of insurance,' resulting in all federal statutes applying to the business of insurance with their 'full rigor.'" *Id.*

The acts the plaintiffs challenge are analytically equivalent to the overcharging for premiums alleged in Merchants Home. There, the plaintiff asserted RICO claims for fraudulent insurance practices by the defendant. *Id.* at 1488. The plaintiff alleged three types of fraudulent practices: (1) overcharging for premiums on actual policies; (2) collecting premiums on fictitious policies; and (3) collecting money from the insured to pay uninsured claims which the insurer did not actually pay. *Id.* We held overcharging for premiums was part of the "business of insurance," though collection of premiums on nonexistent

policies and collecting money from the insured for bogus uninsured claims were not part of such business. *Id.* at 1490.

Consistent with Merchants Home, we conclude the challenged practices in this case of Humana Insurance overcharging premiums and not reducing co-payments is the "business of insurance" for the purpose of the MFA.

The third factor in the preemption analysis is whether the state has enacted a law or laws regulating the challenged acts. We agree with the district court that the Nevada Act was enacted to regulate the acts challenged by the plaintiffs.

In 1971, Nevada adopted the Trade Practices and Frauds; Financing of Premiums Act (Act), N.R.S. § 686A.010, *et seq*. The purpose of the Act was:

> to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the [MFA], 15 U.S.C. §§ 1011 to 1015 inclusive, by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

N.R.S. § 686A.010.

Under the Act, the Nevada Commissioner of Insurance is granted "exclusive jurisdiction" to regulate the trade practices of the business of insurance. N.R.S. § 686A.015. The Act specifically prohibits the dissemination of false or misleading information relating to the sale of policies or benefits. N.R.S. §§ 686A.030 & 686A.040. The plaintiffs'

observation that the Act provides for only administrative remedies does not alter our finding that it regulates the challenged acts. The third factor is satisfied.

Applying the fourth factor, we consider whether the application of RICO would invalidate, impair, or otherwise supersede Nevada's legislation. In *Merchants Home*, we addressed, for the first time, the question whether a federal statute invalidated, impaired, or superseded a state law under section 2(b) of the MFA. *Merchants Home*, 50 F.3d at 1492. As in the present case, the state law in Merchants Home provided for only administrative remedies, but the federal law (RICO) provided for a private right of action. *Id.* We held the application of the federal statute, although it "prohibited" acts which were also prohibited under the state's insurance law, did "not 'invalidate, impair, or supersede' the state's laws under § 2(b) of the McCarran-Ferguson Act." *Id.*

Here, as in *Merchants Home*, there is some symmetry between RICO's private right of action and Nevada's administrative scheme. RICO permits an injured plaintiff to recover for fraudulent practices which the Nevada administrative scheme proscribes. This symmetry, however, does not create a conflict between federal and state law. *Id.* Accordingly, the fourth factor is not present. The MFA does not preclude the plaintiffs' RICO claims.[3]

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[3] The district court cannot be faulted for ruling to the contrary. It did not have the benefit of Merchants Home, decided in 1995, when it rendered its summary judgment in this case.

The next question we consider is whether the plaintiffs produced enough evidence in support of their RICO claims to survive summary judgment.

2. Premium Payors' Claim

To state a claim under RICO, 18 U.S.C. § 1962(c), a plaintiff must demonstrate: (1) the conduct; (2) of an enterprise; (3) through a pattern; (4) of racketeering activity.[4] *Sun Sav. and Loan Ass'n v. Dierdorff*, 825 F.2d 187, 191 (9th Cir. 1987). Racketeering activity is any act indictable under various provisions of 18 U.S.C. § 1961 and includes the predicate acts alleged in this case of mail fraud and wire fraud under 18 U.S.C. §§ 1341 and 1343. *Id.* Mail fraud under section 1341 requires the showing of a scheme to defraud involving use of the United States mails with the specific intent to defraud. *Schreiber Distributing Co. v. Serv-Well Furniture Co.*, 806 F.2d 1393, 1399-1400 (9th Cir. 1986). Wire fraud under section 1343 requires the same showing, but involves use of United States wires. *Id.* at 1400.

The district court held the Premium Payor class failed to demonstrate the requisite causal connection between the

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[4] Title 18 U.S.C. @ 1962(c) provides:

> It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

alleged predicate acts and the asserted damages. The court also held the class failed to demonstrate "concrete financial injury."

To maintain a claim under RICO, a plaintiff must show not only that the defendant's violation was a "but for" cause of his injury, but that it was the proximate cause as well. *Imagineering, Inc. v. Kiewit Pacific Co.*, 976 F.2d 1303, 1311 (9th Cir. 1992), *cert. denied*, 507 U.S. 1004, 123 L. Ed. 2d 266, 113 S. Ct. 1644 (1993). This requires a showing of a direct relationship between the injurious conduct alleged and the injury asserted. *Id.* The plaintiff must show a concrete financial loss. *Id.*

In the present case, the Premium Payor class had to establish that they relied on misrepresentations in buying their insurance policies, and that these misrepresentations directly caused them a concrete financial loss. They contend their claim is simple. Humana, Inc. and Humana Insurance represented to them, through mailings, television and radio commercials, and phone calls, that cost savings would be passed along to them in the form of reduced premiums. They relied on these representations in choosing Humana Insurance as their insurance carrier. The hospital discount Humana Insurance received from Sunrise Hospital was a form of cost saving, yet it was not incorporated into calculation of their premiums. Because their premiums did not reflect these discounts, the Premium Payors contend they suffered a financial loss.

The district court found no evidence in the record to support the Premium Payors' contention that the defendants fraudulently represented how premiums would be calculated.

The class argues the myriad advertisements and promotions did just that. We disagree. The transcript of commercials submitted by the class fails to support their argument. The commercials simply state that because Humana Insurance can "control costs" the employers and employees can save money. The district court accurately described such statements as "puffery." The statements were too general to be interpreted as defining any calculation of insurance premiums.

The class also submitted Humana Insurance's annual reports. Statements in the reports suggested patients were encouraged to attend Humana hospitals "where savings could be shared with employers and their employees through lower premiums." Like the advertisements, this statement did not make a specific representation as to how the premiums would be calculated sufficient to support a cause of action for fraud.

Because we conclude the Premium Payor class failed to come forward with any evidence that the defendants misrepresented how the insurance premiums would be calculated, we do not reach the question of causation. The district court did not err in granting summary judgment against the Premium Payors on their RICO claim.

3. Co-Payors' Claim

The Co-Payors alleged the failure to disclose the Sunrise Hospital discount in the notice of coinsurance obligations sent to them induced them to make inflated co-payments. The Co-Payors were thus allegedly injured by the

defendants' fraudulent failure to reduce their co-payment bills in accordance with the agreed ratio of 80% to 20%.

Although these facts presented at least a triable issue of fact on the Co-Payors' RICO claim, the district court dismissed the claim as barred by the McCarran-Ferguson Act. As we have previously stated, the McCarran-Ferguson Act does not preclude a RICO claim in this case. The district court correctly held, however, that the Co-Payors failed to present any evidence of financial harm resulting from the misrepresentations, except for the amounts they overpaid as a result of the nondisclosure of the discount. Therefore, we affirm the district court's partial summary judgment in favor of the defendants as to any claim by the plaintiffs for RICO damages in excess of these overpayments.

E. Motion To Amend

The plaintiffs contend the district court erred in not granting them leave to amend their complaint. The plaintiffs sought leave to add three additional claims: (1) a RICO conspiracy claim; (2) a claim for obstruction of justice under 18 U.S.C. § 1503; and (3) their previously dismissed state law claims.

We review for abuse of discretion a district court's denial of a motion to amend. *DCD Programs, Ltd. v. Leighton*, 833 F.2d 183, 186 (9th Cir. 1987).

Leave to amend pleadings "shall be freely given when justice so requires." Fed. R. Civ. P. 15(a). We apply this rule with "extreme liberality." *Morongo Band of Mission Indians v. Rose*, 893 F.2d 1074, 1079 (9th Cir. 1990). The following factors guide a court's determination of whether a

motion to amend should be granted: (1) undue delay; (2) bad faith; (3) futility of amendment; and (4) prejudice to the opposing party. *Hurn v. Retirement Fund Trust of Plumbing, Etc.*, 648 F.2d 1252, 1254 (9th Cir. 1981). Of these elements, only the futility issue is relevant in this case.

Because the plaintiffs' state law claims are preempted by ERISA, leave to amend to reassert the state law claims would be futile. The obstruction of justice claim under 18 U.S.C. § 1503 is also futile because 18 U.S.C. § 1503 is a criminal statute that does not provide for a private cause of action. *Hanna v. Home Ins. Co.*, 281 F.2d 298, 303 (5th Cir. 1960), *cert. denied*, 365 U.S. 838, 5 L. Ed. 2d 747, 81 S. Ct. 751 (1961); *Odell v. Humble Oil & Refining Co.*, 201 F.2d 123, 127 (10th Cir.), *cert. denied*, 345 U.S. 941, 97 L. Ed. 1367, 73 S. Ct. 833 (1953). With regard to the proffered RICO conspiracy claim, however, in light of our determination that the Co-Payor class's RICO claim is not barred by the MFA, we conclude the Co-Payor class should be allowed to amend its complaint to assert this claim.

V

CONCLUSION

The district court's grant of summary judgment is affirmed as to the ERISA issues, reversed and remanded as to the Sherman Act antitrust issues, affirmed as to the Premium Payor class's RICO claim, and affirmed as to partial summary judgment on the Co-Payor class's RICO claim. In addition, we grant the Co-Payor class leave to amend its RICO claim to allege a RICO conspiracy. The

plaintiffs shall recover from the defendants one-half of the plaintiffs' cost of appeal.

AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

WALLACE, Circuit Judge, concurring and dissenting:

I concur with the majority in large measure, but its analysis of the antitrust claims in part IV.C. is so troubling that I cannot agree. Although reasonable minds can differ, in this complex economic terrain, I am inclined to the position that the district court did not err in concluding that Forsyth's evidence for a submarket of for-profit hospitals was insufficient to survive summary judgment. The majority's analysis of this issue displays a subtle but important error of market definition theory. I would affirm.

Forsyth contends that Humana monopolized or attempted to monopolize a market for major for-profit acute care hospitals in Clark County, Nevada. The district court held that Forsyth failed to establish the existence of a separate market for for-profit hospitals within the general Clark County hospital market. In holding that there is a genuine factual dispute on this issue, the majority points to two categories of evidence submitted by Forsyth. The first depends on a faulty inference about cross-price elasticity of demand, and the second is insufficient to avoid summary judgment.

As evidence for the existence of a separate market, the majority states that although "UMC charged patients 15 to 20 percent less than Sunrise Hospital, . . . patients with a choice, such as those with insurance, eschewed UMC in

favor of the larger for-profit hospitals despite the significantly lower price at UMC." The majority interprets this consumer behavior as evidence that demand for for-profit hospitals is not responsive to the price charged by non-profit hospitals; "when demand for the commodity of one producer shows no relation to the price for the commodity of another producer, it supports the claim that the two commodities are not in the same relevant market."

The majority's test refers to the economic concept of cross-price elasticity of demand, which is a useful tool for evaluating whether products compete in the same market. Cross elasticity of demand measures the percentage change in the quantity which consumers demand of one product in response to a percentage change in the price of another.

> When the cross-price elasticity of demand for good i with respect to the price of good j is positive, an increase in [the price of] j causes the demand for good i to rise; in that case, the goods are substitutes (as fuel oil and coal). Conversely, if the cross-price elasticity is negative, the goods are complements (as cigars and matches).

2A Phillip E. Areeda, et al., Antitrust Law 105 (rev. ed. 1995). A high cross elasticity of demand indicates that products are close substitutes, and should probably be treated as part of the same market. A low or zero cross elasticity of demand is evidence that products do not compete in the same relevant market.

By focusing on this relationship between the demand for one commodity and the price of another, the majority

attempts to avoid the common but fallacious assumption that expensive products automatically compete in a separate market from inexpensive ones. *See Twin City Sportservice v. Charles O. Finley & Co.*, 512 F.2d 1264, 1274 (9th Cir. 1975) ("the scope of the relevant market is not governed by the presence of a price differential"). The majority reasons that if "patients with a choice" prefer Sunrise hospital even though it is more expensive, then demand for Sunrise "shows no relation" to the prices charged at UMC and the other "indigent" hospitals.

That inference causes me to depart from the majority. We cannot conclude that demand for Sunrise "shows no relation" to the prices at UMC without some evidence of how demand for Sunrise responds to a change in the prices at UMC. Cross elasticity of demand measures a dynamic relationship between two variables: the quantity demanded of product i, and the price of product j. That is, by economic formulation,

$$Eij\ d = - \frac{(\text{change in})\ Qi\ d\ /Qi\ d}{(\text{change in})\ Pj\ /Pj}$$

2A Areeda, Antitrust Law at 105. Cross elasticity cannot be calculated or approximated without information about the quantity demanded of i at (at least) two different prices of j. The record does not reflect that Forsyth introduced any such evidence, and without it the majority's inference is inappropriate.

The following example may help in making my point. Suppose that Ford and Chevrolet each sell a light truck. The Ford has four-wheel drive, and costs $ 2000 more than the Chevrolet, which does not have four-wheel drive. Both trucks sell equally well. If Chevrolet cuts the price of its truck in half and Ford's sales are unaffected, we might infer that the two vehicles are in different relevant markets. But the majority would interpret the simple fact that some consumers buy the Ford, notwithstanding the price differential, as evidence that the trucks do not compete. That reasoning, it seems to me, is faulty.

If four-wheel drive is worth about $ 2000 to most consumers, for example, small changes in the price of the Ford could have a dramatic impact on demand for the Chevrolet. If the availability of the Chevrolet significantly limits the rational pricing strategies for Ford, then the two trucks "compete" in the sense that matters for antitrust market definition. Ford could not exact monopoly profits by raising the price of its truck, because it would lose too many customers to Chevrolet. *See Rebel Oil v. Atlantic Richfield*, 51 F.3d 1421, 1434 (9th Cir.) ("If the sales of other producers substantially constrain the price-increasing ability of the monopolist or hypothetical cartel, these other producers must be included in the market."), *cert. denied*, 133 L. Ed. 2d 424, 116 S. Ct. 515 (1995).

The majority also points to certain documentary evidence, including an expert's affidavit and testimony before the Nevada legislature, which tended to support Forsyth's contention that the "niche" hospitals did not compete with Sunrise. "Niche" sellers are generally

considered to be in the same market with larger, more diverse vendors which carry the same products. *See Thurman Industries v. Pay 'N Pak Stores*, 875 F.2d 1369, 1374-77 (9th Cir. 1989). I do not believe that the district judge erred in concluding that Forsyth's evidence on this point was insufficient to create a triable issue of fact.

APPENDIX B

Memorandum Decision and Order of the District Court
(Decided July 21, 1993)

MARY FORSYTH, MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,
Plaintiffs,

v.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive, Defendants.

CV-S-89-249-PMP (LRL)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEVADA

July 21, 1993, Decided

J. Randall Jones, John Field, Jones, Jones, Close & Brown, Las Vegas, NV, Will Kemp, Harrison Kemp, Chtd., Las Vegas, NV, Stanley M. Chesley, Waite, Schneider, Bayless & Chelley, L.P.A., Cincinnati, OH, John J. Cummings, Richard M. Martin, Jr., W.B. Markovitis, Cummings, Cummings & Dudenhefer, New Orleans, LA, Wendell H. Gauthier, Gauthier & Murphy, Metairie, LA, B. Robert Blakey, Notre Dame Law School, Notre Dame, IN, for plaintiffs.

Dennis Kennedy, Louis Garfinkel, Lionel Sawyer & Collins, Las Vegas, NV, Mark Biros, Joseph E. Casson, Michael F. Moses, Thomas H. Brock, Burton J. Fishman, Lisolette Mitz, Proskauer Rose Goetz & Mendelson, Washington, D.C., Robert Eccles, O'Melveny & Myers, Washington, D.C., for defendants.

PRO, District Judge

Plaintiffs are employers and employees who contracted for health insurance, through employee benefit plans, with Defendant Humana Health Insurance of Nevada, Inc. ("Humana Insurance"), during the period 1985 to 1988. One group of Plaintiffs used the health care services of Humana Hospital-Sunrise ("Sunrise Hospital"), an acute care facility located in Las Vegas, Nevada, which is owned and operated by Defendant Humana, Inc. ("Humana"), and a Participating Hospital under the insurance agreements. The insurance agreements required those insured with Humana Insurance to pay all expenses up to the designated deductible amount, and 20% of the expenses beyond that, with the insurance company to pay the other 80%. The liability of an insured had a cap called a "personal expense limit" which was the maximum the insured would have to pay in any given year, regardless of the total health care expenses.

In 1984, Humana Insurance and Sunrise Hospital entered into an agreement whereby Humana Insurance would pay Sunrise Hospital a discounted amount for that portion of the hospital charges for which it was responsible. However, the portion of the charges paid by the insureds was not discounted but was still based on the usual and customary rates. Plaintiffs assert that Humana Insurance failed to pass

along the discounts it had arranged for itself to its insureds either in the form of reduced premiums or reduced co-payments.

Previous Orders of this Court have granted Plaintiffs' Motions for Class Certification, thereby permitting both a Premium Payor Class and a Co-Payor Class to maintain this action. By their Second Amended Complaint (#370), filed August 12, 1991, Plaintiffs assert three claims for relief. Plaintiffs' First Claim for Relief is brought by the Co-Payor Class which consists of employees who obtained health insurance benefits under an employee benefit plan as defined under the Employment Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq*. There Plaintiffs allege that Defendants breached fiduciary duties owed to the Co-Payor Class under ERISA; engaged in transactions prohibited by ERISA; and retained excessive compensation. Plaintiffs' Second Claim for Relief alleges a violation of Section 2 of the Sherman Act, 15 U.S.C. § 2 and is brought on behalf of the Co-Payor Class and Premium Payor Class, which consists of individuals or entities paying all or a portion of the Humana-Insurance premiums during the period 1985 to 1988. Plaintiffs' Third Claim for Relief, brought on behalf of both the Co-Payor Class and Premium Payor Class, alleges that Defendants engaged in a scheme to defraud in violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961-1968.

Before the Court is a Motion for Summary Judgment (#804), filed on June 22, 1993, by Defendants Humana and Humana Insurance. On July 7, 1992, Defendants filed a Correction (#808). Plaintiffs filed their Opposition (#820) on

August 7, 1992, which was followed by an Errata (#822) filed on August 12, 1992. Defendants filed their Reply (#841) accompanied by a Supplemental Affidavit (#842) on October 19, 1992.

Additionally, the parties have filed the following supplementary motions:

(1) supplement to Plaintiffs' Opposition (#834), filed on September 30, 1992.

(2) Second supplement to Plaintiffs' Opposition (#849), filed on November 16, 1992.

(3) Defendants' Supplemental Memorandum (#868), filed on February 22, 1993. Plaintiffs filed a Third Supplement and Opposition (#890) on May 17, 1993. On June 2, 1993, Defendants filed a Supplemental Memorandum (#895) in response.

(4) Defendants' Second Supplemental Memorandum (#891), filed on May 21, 1993.

(5) Plaintiffs' Fourth Supplement to Opposition (#896), filed on June 8, 1993. Defendants filed a Response (#909), on July 1, 1993.

(6) Defendants' Third Supplemental Memorandum (#901), filed on June 23, 1993. Plaintiffs filed a Response to Defendants' Second and Third Supplemental Memoranda (#908) on July 1, 1993.

(7) Plaintiffs' Response to (#895) and Fifth Supplement to Opposition (#902), filed on June 25, 1993.

(8) Defendants' Supplemental Memorandum of Points and Authorities (#903), filed on June 29, 1993.

(9) Defendants' Fourth Supplemental Memorandum (#910), filed on July 2, 1993.

On July 7, 1993, this Court heard oral argument on Defendants' Motion for Summary Judgment and its progeny.

I. STANDARD OF REVIEW

Pursuant to Federal Rule of Civil Procedure 56, summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

The party moving for summary judgment has the initial burden of showing the absence of a genuine issue of material fact. *See Adickes v. S. H. Kress & Co.*, 398 U.S.144, 26 L. Ed. 2d 142, 90 S. Ct. 1598 (1970); *Zoslaw v. MCA Distrib. Corp.*, 693 F.2d 870, 883 (9th Cir. 1982). Once the movant's burden is met by presenting evidence which, if uncontroverted, would entitle the movant to a directed verdict at trial, the burden then shifts to the respondent to set forth specific facts demonstrating that there is a genuine issue for trial. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986). If the factual context makes the respondent's claim implausible, that party must come forward with more persuasive evidence than would otherwise be necessary to show that there is a genuine issue for trial. *Celotex Corp. v. Catrett*, 477 U.S.

317, 323-24, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986); *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986); *California Arch. Bldg. Prods. v. Franciscan Ceramics*, 818 F.2d 1466, 1468 (9th Cir. 1987), *cert. denied*, 484 U.S. 1006, 98 L. Ed. 2d 650, 108 S. Ct. 698 (1988).

If the party seeking summary judgment meets this burden, then summary judgment will be granted unless there is significant probative evidence tending to support the opponent's legal theory. *First National Bank of Arizona v. Cities Service Co.*, 391 U.S. 253, 290, 88 S. Ct. 1575, 1593, 20 L. Ed. 2d 569 (1968); *Commodity Futures Trading Commission v. Savage*, 611 F.2d 270 (9th Cir. 1979). Parties seeking to defeat summary judgment cannot stand on their pleadings once the movant has submitted affidavits or other similar materials. Affidavits that do not affirmatively demonstrate personal knowledge are insufficient. *British Airways Bd. v. Boeing Co.*, 585 F.2d 946, 952 (9th Cir. 1978), *cert. denied*, 440 U.S. 981, 60 L. Ed. 2d 241, 99 S. Ct. 1790 (1979). Likewise, "legal memoranda and oral argument are not evidence and do not create issues of fact capable of defeating an otherwise valid motion for summary judgment." *Id.*

A material issue of fact is one that affects the outcome of the litigation and requires a trial to resolve the differing versions of the truth. *See Admiralty Fund v. Hugh Johnson & Co.*, 677 F.2d 1301, 1305-06 (9th Cir. 1982); *Admiralty Fund v. Jones*, 677 F.2d 1289, 1293 (9th Cir. 1982).

All facts and inferences drawn must be viewed in the light most favorable to the responding party when

determining whether a genuine issue of material fact exists for summary judgment purposes. *Poller v. CBS*, Inc., 368 U.S. 464, 7 L. Ed. 2d 458, 82 S. Ct. 486 (1962). After drawing inferences favorable to the respondent, summary judgment will be granted only if all reasonable inferences defeat the respondent's claims. *SEC v. Seaboard Corp.*, 677 F.2d 1297, 1298 (9th Cir. 1982).

The trilogy of Supreme Court cases cited above establishes that "summary judgment procedure is properly regarded not as a disfavored procedural shortcut, but rather as an integral part of the Federal Rules as a whole, which are designed 'to secure the just, speedy and inexpensive determination of every action.'" *Celotex Corp.*, 477 U.S. at 327, quoting Fed. R. Civ. P. 1). *See also Avia Group Int'l, Inc. v. L.A. Gear Cal.*, 853 F.2d 1557, 1560 (Fed. Cir. 1988).

II. ERISA

A. Facts & Procedural History

In their First Claim for Relief, Plaintiffs' Co-Payor Class seeks approximately $ 85 million in damages against Defendant Humana Insurance for violation of its fiduciary duties under ERISA.

At the heart of this entire case is a provision within the Humana Care Plus Policy under which members of the Co-Payor Class were insured. This provision states that the employee insured would pay 20% of all covered charges incurred while in a hospital up to a certain amount (usually $ 5,000), and that Humana Insurance would be responsible for the remaining 80%. See Opposition (#820), Exhibit 85

at 7-1 (Humana Insurance master group health insurance policy HCP-84-NV-1).[1] From 1984 to 1988, Humana Insurance obtained substantial discounts, allegedly between 40% and 96%, from Sunrise for services rendered to the insureds in the Co-Payor Class. Errata (#822) at 49-50, Exhibit #39; Opposition (#820), Exhibits 38, 40. Instead of sharing these discounts with the insureds by reducing the amount of co-payments due, Humana Insurance only applied the discount to the amount for which they would have been responsible under the policy. Motion for Summary Judgment (#804) at 10-12.

Based on these actions, the Co-Payor Class asserts that Humana Insurance breached several of its fiduciary duties under ERISA including:

(1) Humana Insurance engaged in a transaction involving the plan on behalf of a party, Sunrise, whose interests were adverse to those of the health benefits plans and/or its participants or beneficiaries in violation of 29 U.S.C. § 1106(b)(2);

(2) Humana Insurance dealt with plan assets in its own interest or for its own account by erroneously interpreting the individual insurance contracts as requiring co-payments based on gross charges and effectuating the co-payment

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[1] Accordingly, in addition to any premiums which were paid to Humana Insurance by the employer or employee, the employee insured would ultimately be responsible for up to $ 1,000 (20% of $ 5,000) before Humana would absorb 100% of covered hospital charges. Errata (#822) at 123-125.

billings through contract administration in violation of 29 U.S.C. § 1106(b)(1);

(3) Humana Insurance received consideration (e.g. the discounts) from Sunrise involving the assets of the plan in violation of 29 U.S.C. § 1106(b)(3);

(4) Humana Insurance did not act in the sole interest of the insureds in interpreting the insurance contracts in violation of 29 U.S.C. § 1104(1)(A)(i);

(5) Humana Insurance failed to discharge its duties with respect to the plan in accordance with the documents and instruments governing the plan in violation of 29 U.S.C. § 1104(1)(D).

See Errata (#822) at 173-193.

On September 26, 1989, this Court denied Defendant Humana Insurance's Motion to Dismiss (#13) the Co-Payor Class' claim for breach of fiduciary duty. In denying Humana Insurance's Motion, this Court held, citing *Sixty-Five Security Plan v. Blue Cross and Blue Shield*, 583 F. Supp. 380, 387 (S.D.N.Y. 1984), *aff'd on reh'g*, 588 F. Supp. 119 (1984), that given the discretion of Humana Insurance to negotiate reimbursement rates on behalf of the health benefit plans, Humana Insurance should be considered a fiduciary under ERISA. Order (#79) at 9. This Court further held that the plain meaning of the contract language indicated that the insureds should have paid 20% of the net hospital charge and not the gross charge, and consequently, by failing to distribute the negotiated discount among the Co-Payor Class, Humana Insurance may have violated its fiduciary duties. *Id.* at 10. Finally, this Court found that

Humana Insurance's failure to reduce its insurance premiums did not constitute a breach of fiduciary duty and that the establishment of co-payment rates was distinguishable from the fiduciary duties imposed in the approval or denial of insurance claims. *Id.* at 6-9, 10.

On July 9, 1991, this Court entered a second Order (#364) which again refused to dismiss the Co-Payor Class' claim for breach of fiduciary duties under ERISA. In the Order, this Court reaffirmed its holding that Humana Insurance was a fiduciary under *Sixty-Five Security Plan* and acknowledged that the Co-Payor Class was also asserting that Humana Insurance engaged in prohibited transactions in violation of 29 U.S.C. § 1106(b). Order (#364) at 4. This Court went on to hold that Plaintiffs were not asserting a claim for benefits[2], but instead were "seeking recovery for having overpaid hospital stays, because Humana Insurance as fiduciary should have acted in their interest and assured that Plaintiffs were not paying based on a 'fraudulent' rate." *Id.* at 6. In addition, in rejecting Humana Insurance's argument that Plaintiffs could not assert a claim for breach of fiduciary relief in their individual capacity, this Court found that:

> This case presents a unique situation in that the whole plan was affected by the alleged breach by Humana Insurance, but there was only monetary harm to individual participants and beneficiaries if

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[2] In the Order, this Court defined a "claim for benefits" as a situation where "an insured puts in a claim and the insurance company denies it." Order (#364) at 6.

and when they were required to pay copayments. The only meaningful remedy is recovery by these individual Plaintiffs, and the provisions of § 1132(a)(3) permit such recovery. *Id.* at 14.[3]

In support of the instant Motion for Summary Judgment on Plaintiffs' ERISA claim, Defendant Humana Insurance advances three alternative arguments: (1) Plaintiffs are precluded from bringing a claim for breach of fiduciary duty since they are seeking relief to benefit only themselves (e.g., the Co-Payor Class) and not the plan as a whole[4]; (2)

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[3] In so doing this Court primarily relied upon a broad interpretation of *Amalgamated Clothing & Textile Workers Union v. Murdock*, 861 F.2d 1406 (9th Cir. 1988) and distinguished the holdings of *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985) and *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986).

[4] Defendant Humana Insurance claims that the total number of insureds who had a co-payment obligation to Humana Hospital Sunrise as a percentage of the number of total insureds was 11.68% (16,412/140,487), whereas the total number of insureds whose co-payment obligation would have declined if their coinsurance was calculated on the discounted amount as a percentage of the number of total insureds was 9.54% (13,049/140,487). Plaintiffs state that the 9.54% is not supported by the evidence, but do concede that not all employees covered under the various health plans were hospitalized at Humana Hospital Sunrise. Opposition (#820), Exhibit 93; Errata (#822) at 207, n.404.

Humana Insurance did not act as a fiduciary in entering into the discount arrangement with Sunrise; and (3) if a claim for breach of fiduciary duty is allowed, monetary relief should be limited to recovery of the allegedly excessive coinsurance payments. Motion for Summary Judgment (#804) at 14-35.

Plaintiffs respond that: (1) this Court has already correctly ruled that regardless of the fact that only the Co-Payor Class was financially injured by Humana Insurance's discounting scheme, since all the insureds were "affected" by the scheme, the Co-Payor Class may properly pursue a constructive trust for Humana Insurance's alleged violations of fiduciary duty; (2) this Court correctly ruled that Humana Insurance was rendered a fiduciary by negotiating a discount with Humana Hospital Sunrise since such an act constituted discretion in the administration of a plan; and (3) under ERISA, damages for Humana Insurance's alleged breach of fiduciary duty should be measured by the sum of the total discount received by Humana Insurance from Sunrise and not simply the percentage of the discount that Humana Insurance should have shared under the terms of the insurance contract.

B. Discussion

1. May the Co-Payor Class Assert a Claim for Breach of Fiduciary Duty?

Notwithstanding this Court's Order (#364) of July 9, 1991, Humana Insurance once again asserts that the Co-Payor Class may not pursue its claims for breach of fiduciary duty, as the class seeks monetary relief on behalf of themselves as individuals and not on behalf of their

respective employee benefit plans. In support of its position, Humana Insurance cites two recent Ninth circuit cases, *Horan v. Kaiser Steel Retirement Plan*, 947 F.2d 1412 (9th Cir. 1991) and *Williams v. Caterpillar, Inc.*, 944 F.2d 658 (9th Cir 1991), as new authority upon which this Court should rely to reverse its earlier decision. Although it does not appear that either of these cases charts new waters in the rough seas of ERISA interpretation, these decisions do present a forceful argument for reconsidering this Court's earlier interpretation of *Russell*, *Sokol*, and *Murdock*. See Order (#364) at 7-14.

To begin, this Court reaffirms its earlier interpretation of *Russell* to the effect that the substantive remedies afforded by 29 U.S.C. § 1109 are limited, and that § 1109 does not allow for the recovery of extra-contractual damages by individual beneficiaries. See Order (#364) at 8-9; *Russell*, 473 U.S. at 142-144. In coming to this conclusion, the Supreme Court in *Russell* specifically found that even though ERISA requires plan fiduciaries to serve the interests of participants and beneficiaries, § 1109 provides remedies for breach of fiduciary duties only on behalf of the plan, and not the individual beneficiary.[5] *Id.* Subsequently, the Ninth

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[5] More specifically, the Supreme Court stated:

> A fair contextual reading of (@ 1109) makes it abundantly clear that its draftsmen were primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary. . . . *[T]he entire text of (@ 1109) persuades us that Congress did not intend to authorize any relief except for the plan itself.*

Russell, 473 U.S. at 142, 144 (emphasis added).

Circuit adopted the reasoning used in *Russell* to foreclose the availability of extra-contractual damages under 29 U.S.C. § 1132(a)(3). *See Sokol*, 803 F.2d at 534-537. In doing so, the Ninth Circuit emphasized, just as the Supreme Court did in *Russell*, that the remedies allowed under § 1132(a)(3) are limited and that § 1132(a)(3) "emphasizes the protection of the plan, not the direct protection of the beneficiaries." *Id.* at 536-537.[6]

The two recent cases cited by Defendant Humana Insurance, *Horan* and *Williams*, restate the interpretation of *Russell* and *Sokol* summarized above. For example, in holding that Plaintiffs in Horan could not bring a claim for breach of fiduciary duty under § 1132(a)(3), the Ninth Circuit stated:

> An individual beneficiary may bring a fiduciary breach claim, but must do so for the benefit of the plan. An individual beneficiary may not pursue a fiduciary breach claim to recover benefits or remedies beyond those provided by a plan. Any

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[6] This Court also recognizes that the position adopted by the Ninth Circuit in Sokol directly contradicts Justice William Brennan's interpretation of @ 1132(a)(3) found in his concurring opinion in *Russell*. See Order (#364) at 9; *Russell* (Brennan, J., concurring) at 153-155; *Sokol*, 803 F.2d at 534-538.

recovery for a violation of sections 1109 and 1132(a)(2) must be on behalf of the plan as a whole, rather than inuring to individual beneficiaries. The Supreme Court reasoned the fiduciary duty provisions in ERISA are primarily concerned with protecting the integrity of the plan, which in turn protects all beneficiaries, rather than remedying each wrong suffered by individual beneficiaries.

We have extended the reasoning in *Russell* to section 1132(a)(3) which allows recovery of 'other appropriate equitable relief.' Section 1132(a)(3) also does not provide an action for an individual beneficiary to recover extra-contractual remedies. Under *Russell* and *Sokol*, the plaintiffs fail to present a fiduciary breach claim if the only remedy sought is for their own benefit, rather than for the benefit of the Plan as a whole.

Horan 947 F.2d at 1417-18 (citations omitted). Similarly, in *Williams* the Ninth Circuit recognized that "the Supreme Court has held that equitable relief under ERISA is limited to relief protecting the integrity of the plan as a whole and does not extend to individual plan participants." *Williams*, 944 F.2d at 665.

In this Court's previous Order (#364) of July 9, 1991, it found that, based on *Murdock* and § 1132(a)(3), the only "meaningful remedy" in this case would be to allow the Co-Payor Class to sue Humana Insurance for breach of fiduciary duty. See Order (#364) at 14. In light of the additional clarification yielded by the *Horan* and *Williams*,

this Court now recognizes that this conclusion was incorrect.

First, it is undisputed that the members of the Co-Payor Class are seeking approximately $ 85 million in damages in their individual capacity for various breaches of fiduciary duty pursuant to § 1132(a)(3). As set forth in *Sokol*, *Horan*, and *Williams*, however, § 1132(a)(3) does not allow individual beneficiaries to sue for a breach of fiduciary duty on their own behalf. *See Horan* 947 F.2d at 1417-18; *Williams*, 944 F.2d at 665; *Sokol*, 803 F.2d at 536-537.

Second, this Court's previous reliance on *Murdock* as authority for allowing the Co-Payor Class to seek damages under § 1132(a)(3) must be acknowledged as tenuous. Although the Court in *Murdock* did allow plan beneficiaries (and not the plan itself) to benefit from a constructive trust funded with the ill-gotten profits of the plan administrator, the Court in *Murdock* also limited its ruling to the "circumstances of this case." *Murdock*, 861 F.2d at 1417. These circumstances included the fact that (1) the ERISA plan which had been defrauded no longer existed, (2) under the terms of the plan (which were altered by the errant fiduciary) any damages paid to the plan would have simply reverted to the wrongdoer, and (3) the damages to be received for the breach of fiduciary duty were to be put into a constructive trust in favor of all plan participants. *Id.* at 1408-09, 1417.

Here, although Defendants' conduct as alleged by Plaintiffs is clearly questionable, the level of impropriety

alleged is less severe than that which occurred in *Murdock*.[7] The injury in *Murdock* was directed primarily against the plan and not against particular beneficiaries, the various benefit plans purportedly affected by Humana Insurance's breach of fiduciary duty still exist, and, most importantly, this Court's prior Order (#364) would afford relief only to a select group of beneficiaries. Upon reconsideration and based on these distinctions, this Court finds that *Murdock* does not provide persuasive authority to support this Court's earlier interpretation of § 1132(a)(3).[8]

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[7] In *Murdock*, the fiduciary used plan assets to further a "greenmail" scheme to benefit his own individual assets. After the scheme was successful (with both the plan and the fiduciary making substantial profits as a result), the fiduciary then amended the plan so that any excess funds would revert to the administrator. With the plan so changed, the fiduciary then paid all beneficiaries the value of their vested interests under the plan and retained all excess monies for himself (e.g. the profits made by the plan based on the use of its assets in the greenmail scheme). *Murdock*, 861 F.2d at 1408-1409.

[8] In the July 9, 1991 Order (#364), this Court also cited *Call v. Sumitomo Bank*, 881 F.2d 626, 631-32 (9th Cir. 1989) for the proposition that the *Russell* decision should not be narrowly construed. This Court now concludes that the language used for this proposition was dicta, and furthermore, that the Court in *Call* itself recognized that "'ERISA grants no private right of action by a beneficiary *qua* beneficiary; rather it *accords beneficiaries the right to sue on behalf of the entire plan* if a fiduciary breaches the plan's terms.'" *Id.* at 632, n. 13 (citing *Sokol*). *See also*

Finally, this court also recognizes that a claim for breach of fiduciary duty is neither the only nor the most appropriate remedy for the wrongs asserted by the Co-Payor Class. After careful consideration of the facts and the injury alleged by the Co-Payor Class in this case, it is clear that the crux of the current dispute rests on the reasonableness of Humana Insurance's interpretation of the co-payment provision in the insurance contract. Such a claim is more appropriately brought pursuant to 29 U.S.C. § 1132(a)(1)(B) which allows a beneficiary to seek benefits due under the terms of the plan. *See e.g., Eaton v. Blue Cross and Blue Shield of Alabama*, 681 F. Supp. 759, 760-62 (S.D. Ala. 1988). Accordingly, this Court finds that the cause of action provided by ERISA to compensate the Co-Payor Class for the questionable conduct of Humana Insurance is a claim for benefits pursuant to § 1132(a)(1)(B) and not a claim for breach of fiduciary duty under §1109 or § 1132(a)(3).[9]

Murdock, 861 F.2d at 1417.

[9] This Court also recognizes that in its Motion for Summary Judgment (#804), Humana Insurance concedes that such a claim is proper, and has stipulated that to the extent the Co-Payor Class would be required to exhaust their administrative remedies prior to bringing a claim for benefits, such a requirement would be waived. See Motion for Summary Judgment (#804) at 22. In addition, this Court finds that to avoid any unjust enrichment on the part of Humana Insurance, Plaintiffs would be entitled individually to obtain prejudgment interest for any relief provided under @ 1132(a)(1)(B). *Rivera v. Benefit Trust Life Ins. Co.*, 921 F.2d 692 (7th Cir. 1991); *Short v.*

In sum, based on the holdings in *Horan*, *Williams* and *Sokol*, the limited precedential value of *Murdock*, and the availability of a more appropriate remedy pursuant to § 1132(a)(1)(B), this Court finds that the Co-Payor Class should not be allowed to pursue claims against Humana Insurance for breach of fiduciary duty. Accordingly, this Court hereby modifies its earlier Order (#364) of July 8, 1991, and will grant Humana Insurance's Motion for Summary Judgment as to the first claim for relief set forth in Plaintiffs' Second Amended Complaint (#370). Plaintiffs' Co-Payor Class will be permitted, however, to file a Third Amended Complaint seeking appropriate relief under § 1132(a)(1)(B).

2. Damages

This Court also finds that even if it were to allow Plaintiffs' Co-Payor Class to seek a claim for breach of fiduciary duty, Humana Insurance would still be entitled to partial summary judgment on the issue of damages.

Plaintiffs argue that "equity and poetic justice" require that Humana Insurance pay to the beneficiaries the entire discount it obtained from Sunrise.[10] Errata (#822) at 126. In

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Central States, S.E. & S.W. Areas Pension Fund, 729 F.2d 567, 576 (8th Cir. 1984); *see also Blanton v. Anzalone*, 760 F.2d 989, 992-93 (9th Cir. 1985).

[10] The following discussion regarding the proper manner in which to calculate damages is applicable to a theory of liability predicated upon both @ 1132(a)(1)(B) and breach of fiduciary duty. Thus, although this Court has

contrast, Humana Insurance asserts that Plaintiffs' calculations are incorrect, and that the appropriate measure of damages in this case would be simply a refund of the overcharged co-payment. See Reply (#841) at 22-27.

Section 1109(a) provides that:

> Any person who is a fiduciary with respect to the plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make

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disallowed Plaintiffs' fiduciary duty claim, this ruling does not affect the measure of damages to be awarded to Plaintiffs. Using the example provided by Plaintiffs, assume the following:

(1) Gross hospital charge = $ 5,000.
(2) Amount paid by insured = $ 1,000 (.20 X $ 5,000).
(3) Amount paid by Humana Insurance after taking an 89% discount = $ 550 (.89 X $ 5,000).
(4) Total amount paid to Sunrise = $ 1,550 ($ 1,000 + $ 550).

Plaintiffs argue that appropriate damages for Humana Insurance's breach of fiduciary duty would be to require it to "disgorge the entire 'secret' discount" obtained by Humana Insurance from Sunrise. Based on their statement that "disgorgement of the unilateral discounts actually requires Humana Insurance to pay 80% of the gross charges," this amount would presumably be $ 3,450 ($ 4,000 (.80 X $ 5,000) - $ 550). See Errata (#822) at 123-26.

> good to such plan any losses to the plan resulting from such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including the removal of such fiduciary.

Similarly, under § 1132(a)(3), a "beneficiary" may seek "other appropriate equitable relief" to redress breaches of fiduciary duty or to enforce the provisions or terms of the plan.

"Where there has been a breach of fiduciary duty, ERISA grants to the Courts broad authority to fashion remedies for redressing the interests of participants and beneficiaries." *Donovan v. Mazzola*, 716 F.2d 1226, 1235 (9th Cir. 1983), *cert. denied*, 464 U.S. 1040, 79 L. Ed. 2d 169, 104 S. Ct. 704 (1984). Notwithstanding this, any loss or profit which is disgorged as a result of a breach of fiduciary duty must have a causal connection with the breach. *Leigh v. Engle*, 727 F.2d 113, 137 (7th Cir. 1984). Uncertainties in the determination of damages, however, should be resolved against the wrongdoer. *Kim v. Fujikawa*, 871 F.2d 1427, 1431 (9th Cir. 1989); *Leigh*, 727 F.2d at 138-39.

Plaintiffs argue that they are entitled to the entire discount yielded by Sunrise as this amount constitutes the ill-gotten profits Humana Insurance obtained as a result of its breach. The difficulty with Plaintiffs' position, however, is that their calculation ignores the facts of the case and has no "causal connection" to the breach.

To illustrate this, assume, as Plaintiffs do, that on a gross hospital charge of $ 5,000, the insured beneficiary paid $ 1,000 in co-payments and Humana Insurance paid $ 550 on its obligation. The net amount received by Sunrise equals $ 1,550, and the net discount given by the hospital amounts to $ 3,450.[11] Assuming Plaintiffs are correct in their interpretation of the co-payment provision that the insureds were responsible for 20% of the net charges and not the gross charges,[12] the amount which should have been paid by the insureds is $ 310 (.20 X $ 1,550). Therefore, since the insured paid $ 1,000 rather than the $ 310 which was required under the contract, the insured overpaid, and Humana Insurance profited, $ 690.

As illustrated above, it is clear that the amount asserted by Plaintiffs, or $ 3,450, is not a true measure of Humana Insurance's "ill-gotten profit." To adopt this figure would ignore the reality that the gross hospital charge ($ 5,000) was never in fact paid and would contradict Plaintiffs' interpretation of the co-pay provision that the 20/80 split should apply only on the net hospital charge ($1,550). Accordingly, since Plaintiffs' measure of damages fails to

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[11] Note that the net discount given on the hospital bill is 69% ($ 3,450/$ 5,000) and the net discount given on the portion of the bill for which Humana Insurance was responsible is 86.25% ($ 3,450/$ 4,000) Accordingly, Plaintiffs' assertion that Humana Insurance received an 89% discount is inaccurate. See *supra*, n. 10; Errata (#822) at 124-125.

[12] See Second Amended Complaint (#370) at 8.

establish a "causal connection" between the actual profits obtained by Humana Insurance and its breach of fiduciary duty, their calculation of damages must be rejected.

The proper measure of damages would be to restore the trust beneficiaries to the position they would have occupied but for the breach of trust. *Donovan v. Bierwirth*, 754 F.2d 1049, 1056 (2nd Cir. 1985). Applying this remedy to the facts of the present situation, Humana Insurance would be required to disgorge the amount of the discount which it should have paid under the proper interpretation of the co-pay provision. Using the hypothetical insured described by Plaintiffs, this would amount to $ 690. In so doing, the primary purpose of § 1109(a) to "undo" the harm caused by the breach of fiduciary duty would be realized. The interests of the beneficiaries would be furthered by removing the fiduciary's ill-gotten profits, and consistent with the holding in *Leigh*, only those profits which are "causally connected" with Humana Insurance's breach of fiduciary duty would be disgorged. *See Leigh*, 727 F.2d at 138-139; *Bierwirth*, 754 F.2d at 1056.[13]

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[13] In their Fourth Supplemental Opposition (#896) Plaintiffs argue that the recent United States Supreme Court case *Mertens v. Hewitt Assocs.*, 124 L. Ed. 2d 161, 113 S. Ct. 2063, 61 U.S.L.W. 4510 (1993), stands for the proposition that this Court has the ability to create a trust composed of all discounts yielded by Sunrise to Humana Insurance as a remedy for Humana Insurance's alleged breach of fiduciary duty. This Court disagrees. The primary holding of *Mertens* is that "appropriate equitable relief" under @ 1132(a)(3) does not permit compensatory

Accordingly, even if the Co-Payor Class could assert a claim for breach of fiduciary duty under the present facts, partial summary judgment would still be appropriate in this case with respect to Plaintiffs' excessively broad view of "ill-gotten profits."[14]

Leave to Amend Plaintiffs' Complaint.

In their Opposition, Plaintiffs argue that in the "unlikely event that this Court completely reverses itself and rules that ERISA offers no remedy to Plaintiffs," this Court should allow Plaintiffs to reinstate their state law claims. Errata (#822) at 95, n.2. This Court disagrees.

First, under this Order, Plaintiffs are not without an ERISA remedy. The Co-Payor Class properly may file an Amended Complaint to state a claim under § 1132(a)(1)(B). See *supra* at 17. Moreover, Plaintiffs' state law claims (which would apply to Plaintiffs' recent proposed claim

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losses for breaches of fiduciary duty, but rather only traditional forms of equitable relief such as injunction, mandamus, and restitution of ill-gotten profits. 61 U.S.L.W. at 4513-14. Such a holding does not aid Plaintiffs because, as discussed above, Plaintiffs' argument that the entire discount yielded by Sunrise to Humana Insurance are Humana Insurance's "ill-gotten profits" is erroneous.

[14] In light of this Court's findings regarding the Co-Payor Class' inability to pursue a claim for breach of fiduciary duty, this Court need not address Defendants' second argument that Humana Insurance was not a fiduciary when it negotiated the discount with Sunrise.

under Nevada's RICO statute, N.R.S. § 207.470) are preempted by ERISA. See Order (#79) at 14-15; *Olson v. General Dynamics Corp.*, 960 F.2d 1418, 1420-23 (9th Cir. 1991), *cert. denied*, 119 L. Ed. 2d 588, 112 S. Ct 2968 (1992); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 493-494 (9th Cir. 1988), *cert. denied*, 492 U.S. 906, 106 L. Ed. 2d 566, 109 S. Ct. 3216 (1980).

Finally, as this Court has indicated previously, given the procedural history of this case which has seen three extensive rounds of dispositive motions, to allow the parties to address new theories of liability would strain the letter and spirit of Fed. R. Civ. P. 15(a).

Accordingly, Plaintiffs' request to reinstate their prior state law claims was properly denied in this Court's October 13, 1992 Order (#840), and will not be reconsidered here.

III. ANTITRUST

A. Facts

Plaintiffs' Second Claim for Relief seeks approximately $ 181 million in damages against Defendants Humana and Humana Insurance for monopolization or attempted monopolization under section 2 of the Sherman Act, 15 U.S.C. § 2. The "Antitrust Class" consists of individual employees and employers who allegedly paid excessive policy premiums and co-payments to Humana and Humana Insurance between 1985 and 1988. See Second Amended Complaint (#370) at 11, P 41; 17, P 51.

In their opposition, Plaintiffs argue that Humana and Humana Insurance monopolized or attempted to monopolize two independent submarkets including: (1) Clark County for-profit acute care hospitals; and (2) those hospitals used by Humana Insurance's insureds. Errata (#822) at 290-292.

As proof of this actual or attempted monopolization, the Antitrust Class alleges that during the relevant time period, Humana made "supracompetitive" or "monopoly" profits.[15] Plaintiffs maintain that with regard to the for-profit acute care hospital submarket, Sunrise had "60% of the licensed beds" and derived "58.6% of the total gross patient revenues excluding medicare and medicaid patients" during the relevant time period. *Id.* at 305. Also, with respect to the submarket of hospitals used by Humana Insurance's

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[15] In support of the assertion that Humana made "supracompetitive" profits, Plaintiffs allege that: (1) Nevada hospitals have the highest profit margins in the country and that Sunrise was the most profitable hospital in Nevada; (2) Sunrise was the most profitable hospital in the Humana organization; (3) Notwithstanding the fact that Sunrise's market share decreased during the relevant time period, its net operating revenue during this period increased; and (4) During 1988 when Nevada's cost containment statute was in place, Sunrise's operating margin was excessive compared to other hospitals nationally. Errata (#822) at 278-81.

insureds, Plaintiffs allege that Sunrise enjoyed an 80% share within this market. *Id.*[16]

Plaintiffs claim that in order to maintain or enhance its monopolistic position, Defendants acted anti-competitively in several ways, including: (1) Humana refused to unbundle level III neonatal care to other health care plans; (2) Humana improperly diverted critical care patients to other hospitals; (3) Humana threatened to revoke physician office space if they did not admit patients to Sunrise; (4) the discount arrangement between Humana and Humana Insurance allowed Sunrise to understate hospital profits and avoid regulatory cost containment while misleading its insureds; (5) Humana threatened physicians and lawmakers who challenged its practices; and (6) Humana Insurance improperly tied use of its insurance policy with treatment at Sunrise. Errata (#822) at 283-290.

Finally, with regard to the antitrust injury suffered by the Antitrust Class, Plaintiffs allege that, as a result of Defendants' monopolistic activity, its members were forced to pay excessive co-payments and insurance premiums. Errata (#822) at 276-77, 308-311.

B. Discussion

1. Elements of a Section 2 Claim

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[16] The only evidence that Plaintiffs submit in support of this allegation of market share is a December 7, 1984 memo which states that "non-Humana usage was 19%" for Humana insurance insureds. Errata (#822) at 305; Exhibit 132.

In order to prevail on a claim of monopolization under Section 2 of the Sherman Act, a plaintiff must demonstrate: (1) possession of monopoly power in the relevant market; (2) willful acquisition or maintenance of that power; and (3) causal antitrust injury. *Oahu Gas Service, Inc. v. Pacific Resources, Inc.*, 838 F.2d 360, 363 (9th Cir. 1988), *cert. denied*, 488 U.S. 870, 102 L. Ed. 2d 149, 109 S. Ct. 180 (1988).

To establish a Section 2 claim for an attempt to monopolize, a plaintiff must demonstrate four elements: (1) specific intent to control prices or destroy competition; (2) predatory or anti-competitive conduct directed toward accomplishing that purpose; (3) a dangerous probability of success; and (4) causal antitrust injury. *McGlinchy v. Shell Chemical Co.*, 845 F.2d 802, 811 (9th Cir. 1988).

Both market definition and market power are essentially questions of fact, whereas questions of whether specific conduct is anti-competitive or whether a party has standing to assert a violation of the Sherman Act are questions of law. *Austin v. Blue Cross and Blue Shield of Alabama*, 903 F.2d 1385, 1387 (11th Cir. 1990); *Oahu*, 838 F.2d at 363, 368.

2. The Need for Market Analysis

As an initial matter, Plaintiffs argue that they need not formally define a "relevant market," as Humana and Humana Insurance made "supracompetitive profits" during the relevant time period, and that this alone adequately demonstrates market power. Errata (#822) at 278-283. Such an argument is without merit.

First, by definition, any allegation that Defendants made "excessive" profits necessarily requires that Plaintiffs compare the profit performance of Humana with that of its competitors. See Kinter, *Federal Antitrust Law*, § 12.10, at 361 (1980). To argue, as Plaintiffs do, that Defendants' profits were "excessive" without knowing what the relevant market was or who its competitors were renders any antitrust analysis vacuous.

Second, although prior Ninth Circuit law has held that a detailed market analysis is not uniformly fatal to a claim under the Sherman Act, in order to avoid such an analysis a plaintiff must be able to demonstrate that the anti-competitive acts alleged actually resulted in detrimental effects on competition. *Bhan v. NME Hosp., Inc.*, 929 F.2d 1404, 1413 (9th Cir.), *cert. denied*, 116 L. Ed. 2d 639, 112 S. Ct. 617 (1991); Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd.24, 924 F.2d 1484, 1489 n.3 (9th Cir. 1991); *Thurman Industries, Inc. v. Pay 'N Pak Stores, Inc.*, 875 F.2d 1369, 1373 (9th Cir. 1989); *Oltz v. St. Peter's Community Hospital*, 861 F.2d 1440, 1448 (9th Cir. 1988) (no need for detailed market analysis where evidence clearly demonstrated competitive harm to patient market in Helena through increase of price and decrease in competition for anesthesiological services). In the present case, Plaintiffs rely on conclusory allegations that Defendants made excessive profits and do not explain how these profits have resulted from anti-competitive conduct. See Errata (#822) at 278-83. Such allegations clearly do not demonstrate a definable

market or demonstrate market power which would obviate the need of a proper market analysis.[17]

Finally, even though courts have allowed proof of excessive profits to be used as evidence of market power, such proof may be misleading and subject to various interpretations. See Kinter, § 12.10; Areeda & Turner, *Antitrust Law*, § 507-516 (1978). As such, citing excessive profits without a more detailed analysis of the meaning of such profits is unsatisfactory proof of market power. *Telerate Systems, Inc. v. Caro*, 689 F. Supp. 221, 238 (S.D.N.Y. 1988).

Accordingly, since allegations of Defendants' "excessive" profits do not clearly demonstrate market power or detrimental effects on competition, Plaintiffs still have the burden of proving that Defendants exercised monopoly power within the boundaries of a properly defined competitive market.

3. Defining the Relevant Market

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[17] This Court also recognizes that the Ninth Circuit's decisions on this point have been called into doubt by the United States Supreme Court's recent decision, *Spectrum Sports, Inc. v. McQuillan*, 122 L. Ed. 2d 247, 113 S. Ct. 884 (1993). *Spectrum Sports* held that an inquiry into market definition and market power is a prerequisite for a claim of attempted monopolization under @ 2 of the Sherman Act. *Id.* at 891-92. Even without regard to *Spectrum Sports*, however, it is clear that Plaintiffs have not satisfied Ninth Circuit precedent which limits the necessity of a market analysis.

Under Section 2, "defining the relevant market is indispensable to a monopolization claim." *Thurman Industries, Inc.*, 875 F.2d at 1373. A market is typically defined as the pool of goods or services that qualify as economic substitutes because they enjoy reasonable interchangeability of use and cross-elasticity of demand. *Morgan*, 924 F.2d at 1489; *Thurman*, 875 F.2d at 1373. The determination of a market usually requires an inquiry into the nature of the product and the geographic areas of effective competition. *Oahu*, 838 F.2d at 364. "For antitrust purposes, defining the product market involves the identification of the field of competition; the group or groups of sellers or producers who have actual or potential ability to deprive each other of significant levels of business," while "a geographic market is an area of effective competition where buyers can turn for alternate sources of supply." *Morgan*, 924 F.2d at 1489-90; *see also Bhan*, 669 F. Supp. 998, 1018-19 (E.D.Cal. 1987), *affirmed*, 929 F.2d 1404 (9th Cir.), *cert. denied*, 116 L. Ed. 2d 639, 112 S. Ct. 617 (1991) (another consideration in defining product market may be production dimension which is the ability of competing firms to easily supply a good or service if one firm limits its output). Finally, the plaintiff has the burden of proving the scope of the relevant market. *Id.* at 1019.

4. Plaintiffs' Relevant Markets

Plaintiffs offer two distinct markets which they contend Defendants monopolized or attempted to monopolize. These include: (1) those hospitals used by Humana Insurance insureds; and (2) all major for-profit acute care hospitals in Clark County, Nevada. Errata (#822) at 290-292. Plaintiffs,

however, fail to present sufficient evidence to support these market definitions.

a. Hospitals Used by Humana Insurance Insureds

With regard to those hospitals used by Humana Insurance insureds, Plaintiffs offer no facts to support such a market definition other than to refer to a recent United States Supreme Court decision *Eastman Kodak Co. v. Image Technical Services*, 119 L. Ed. 2d 265, 112 S. Ct. 2072 (1992), and conclude that the hospitals used by Humana Insurance insureds should be considered a relevant submarket. Errata (#822) at 291-292; 304-305. Providing no factual or legal basis for such a submarket, Defendants are entitled to summary judgment on this aspect of Plaintiffs' Section 2 claims. See *Seidenstein v. National Medical Enterprises, Inc.*, 769 F.2d 1100, 1106 (5th Cir. 1985); *Drs. Steuer & Latham v. Nat. Med. Enterprises*, 672 F. Supp. 1489, 1514 (D.S.C. 1987).[18]

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[18] Even if this Court were to accept the argument that the hospitals used by Humana Insurance insureds could constitute a relevant submarket, Plaintiffs fail to address: (1) the fact that Humana insureds were able to (and did) easily switch health insurance policies; (2) the fact that under the Humana policy, Plaintiffs were not precluded from choosing hospitals other than Sunrise; and (3) what other hospitals were competing within this market. See Reply (#841) at 72-75. Failure to address these facts clearly precludes finding the existence of Plaintiffs' proposed submarket.

b. Major For-Profit Acute Care Hospitals

The second market which Plaintiffs maintain Defendants monopolized or attempted to monopolize is that of major for-profit acute care hospitals in Clark County. This market allegedly consists of three hospitals, including Sunrise, valley Hospital ("Valley"), and Desert Springs Hospital ("Desert Springs"), and excludes Clark County's five remaining acute care hospitals, Boulder City Hospital ("Boulder City"), Community Hospital of North Las Vegas ("Community"), St. Rose De Lima Hospital ("St. Rose"), University Medical Center ("UMC"), and Women's Hospital ("Women's"). Errata (#822) at 291. In support of this market definition, Plaintiffs assert the following facts:

(1) Only Sunrise, Valley, Desert Springs, and University Medical Center ("UMC") have a comparable range of hospital services;

Further, to the extent Plaintiffs rely on the *Kodak* decision to support a claim for an illegal tying arrangement between Humana and Humana Insurance, such a claim is without merit as the undisputed facts indicate that Humana Insurance never possessed sufficient market share to exercise market power within the group health insurance market. See Reply (#841), Exhibit N, Supplemental Affidavit of Barry C. Harris at 16-22 (Humana Insurance's share of Clark County residents covered by commercial health insurance was the following - 1984/4%, 1985/18%, 1986/24%, 1987/17%, 1988/15%); *Barry v. Blue Cross of California*, 805 F.2d 866, 870-74 (9th Cir. 1986); *Ezpeleta v. Sisters of Mercy Hospital Corp.*, 800 F.2d 119, 121-122 (7th Cir. 1986).

(2) Humana Insurance contracted with Boulder City, Community, and St. Rose to be preferred providers in its insurance program;

(3) Donald Stewart, Executive Director of Sunrise, when testifying before the Nevada Senate, stated that the smaller primary care hospitals in Clark County do not compete against the large hospitals;[19]

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[19] More specifically, on May 20, 1987, Donald Stewart testified:

> Large, full service hospitals with the latest in medical technology compete vigorously against each other for market share. However, smaller primary care hospitals, charging less and not providing as specialized or technical care have found a niche in the market. For the most part, the larger hospitals do not compete against them.
>
> That will change with this bill. By forcing a rollback of our billed charges and a deep reduction in revenue per admission, the state will prevent us from being the kind of hospital we want to be, and force us and other large hospitals into markets we currently avoid.
>
> If you limit our prices and our revenue per admission, the only response left to us in the market is to increase our volume. This will require expanding into markets we don't currently pursue and competing directly for the segments of the market that are the mainstay of smaller hospitals. . . . The marketplace is dynamic and changing. You cannot change that by legislation. See Errata (#822), Exhibit 125, at 7-8.

(4) UMC did not compete in the same market since it charged lower prices for its services and, being a non-profit county hospital, was perceived to be the "indigent" hospital in Clark County;[20]

Errata (#822) at 290-305.

In analyzing Plaintiffs' second alleged market, the primary issue to be decided is whether Plaintiffs have presented sufficient evidence to support their allegation that the relevant service market for antitrust purposes consists of

[20] Plaintiffs also allege that physicians who practiced at Valley often did not admit its patients to UMC. See Errata (#822) at 299. Even if this fact is true, this Court fails to see how it helps to establish that UMC and Sunrise were not competitors.

Clark County's major for-profit acute care hospitals.[21] This Court finds that Plaintiffs have failed to do so.

Plaintiffs' assertion that Boulder City, Community, St. Rose, and Women's are not competitors of Sunrise because they do not offer a comparable range of hospital services misconstrues the alleged injury in this case. Although this Court would agree with the proposition that certain hospital services under certain facts may constitute a relevant submarket,[22] throughout this litigation Plaintiffs have not claimed or offered any evidence regarding the

[21] There is really no dispute as to the geographic market in this case. As established by Defendants' experts, the consumers in the market in which Sunrise competes regularly seek care at hospitals throughout Clark County. See Motion for Summary Judgement (#804) at 64-72; Reply (#841) Exhibit N, Supplemental Affidavit of Barry Harris, at 6-8, 13-14; Exhibit Z, Supplemental Affidavit of Harold M. Ting, at 21. Although Plaintiffs raise the point that UMC may be in a different geographic area than Sunrise, such an assertion is easily refuted by the analysis presented by Defendants' experts, the fact that UMC is only 3 miles away from Sunrise, and the fact that Valley Hospital, which Plaintiffs assert is a competitor of Sunrise, is in the same "western" location and is further from Sunrise than UMC. See *id.*; Reply (#841), Exhibit N, Supplemental Affidavit of Harold M. Ting, at Exhibit 4.

[22] *See, e.g., Morgan*, 924 F.2d at 1488-89 (radiology services constitute relevant market); *Oltz*, 861 F.2d at 1446-48 (patient anesthesiological services constitute relevant market.).

monopolization of specific hospital services such as open heart surgery or renal dialysis, etc. See Errata (#822) at 297. The antitrust injury alleged by Plaintiffs in this case is the actual or attempted monopolization of the general acute care hospital market in Clark County. See Errata (#822) at 313-315. Given that Boulder City, Community, St. Rose, and Women's all offer a variety of hospital services within this market, these hospitals have the ability to deprive Sunrise of significant levels of business and therefore, must be considered to be competitors of Sunrise. See Reply (#841) at 99-105; Errata (#822) at 296-97; *Morgan*, 924 F.2d at 1489 (competitors are "the group or groups of sellers or producers who have actual or potential ability to deprive each other of significant levels of business"); *Thurman*, 875 F.2d at 1374-1377 (specialty stores selling same products as more comprehensive home centers within same competitive market); *see also United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990), *cert. denied*, 498 U.S. 920, 111 S. Ct. 295, 112 L. Ed. 2d 249 (1990); *Weiss v. York Hosp.*, 745 F.2d 786, 826 (3rd. Cir. 1984), *cert. denied*, 470 U.S. 1060, 84 L. Ed. 2d 836, 105 S. Ct. 1777 (1985); *United States v. Carilion Health Service*, 707 F. Supp. 840, 847 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1990).

Plaintiffs further allege that Boulder City, Community, and St. Rose are not competitors of Sunrise because these three hospitals are also preferred providers under the Humana insurance policy. Although it is true that to Humana Insurance insureds, having preferred provider status at Boulder City, Community, and St. Rose made these hospitals more competitive with Sunrise and with each other, the

simple fact remains that the acute care hospital service market in Clark County does not serve only Humana Insurance insureds. See *supra* at n. 18 (Humana Insurance's percentage of Clark County residents with medical insurance was 15% to 24% during relevant time period). Accordingly, because these institutions competed for patients independent of any relationship which they might have had with Humana Insurance, any argument raised by Plaintiffs that these hospitals did not compete in the same market as Sunrise must be rejected.[23]

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[23] Plaintiffs also rely on the affidavit of Victor Brewer and the testimony of Donald Stewart to support their argument that the smaller hospitals did not compete in the same market as Sunrise. With regard to Victor Brewer's affidavit, except for his statement regarding physician overlap between Community and Sunrise, the statements contained therein are conclusory allegations insufficient to raise a question of material fact. See Errata (#822), Exhibit 112. As to Donald Stewart's testimony, apart from being in the context of trying to sway the Nevada legislature from further regulating the hospital industry, the clear gravamen of these statements was that even though the larger hospitals in Clark County participated in the same marketplace as the smaller hospitals, they chose not to focus their marketing resources on pursuing this share of the market. See *supra* at n.19. Furthermore, to the extent that Stewart's statements could be inferred to support Plaintiffs' conclusion that Sunrise did not seek to compete vigorously against the smaller hospitals in Clark County, this statement alone does not raise a material question of fact with regard to whether these smaller hospitals acted as a competitive constraint on the same

Finally, Plaintiffs argue that UMC should not be considered a competitor of Sunrise because UMC charged lower prices than other hospitals, and because it is a non-profit county hospital, UMC was perceived to be the "indigent" hospital. This Court finds such arguments unpersuasive.

First, the facts in this case reveal that during the relevant time period UMC offered a wide range of acute care hospital services and had contracts for these services with nearly all managed care plans in Nevada. See Motion for Summary Judgment (#804) at 74-76; Exhibit #120; Exhibit #122; Exhibit #123; Exhibit #125 at 51-60. In addition, UMC competed with Sunrise for beds under Certificate of Need applications, attempted to recruit doctors from other Las Vegas hospitals, upgraded its facilities and equipment, and advertised to improve its public image. *Id.* at 77-78; Exhibit #122; Exhibit #125 at 60-62; Exhibit #129; Exhibit #131; Exhibit #133; see also Supplemental Affidavit of Harold M. Ting (#842), Exhibit 8 (UMC's 1989-1990 marketing plan which identifies Sunrise as a competitor). Such factors clearly demonstrate that UMC was a significant competitor for patients in Clark County's acute care hospital market.

With regard to Plaintiffs' pricing argument, as the Ninth Circuit has recognized before, "the scope of the relevant market is not governed by the presence of a price differential between competing products." *Twin City Sportserv., Inc. v.*

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general acute care hospital services offered by the larger hospitals.

Charles O. Finley & Co., 512 F.2d 1264, 1274 (9th Cir. 1975). This is particularly so where, as here, the pricing for hospital services commonly is subject to discounting through third-party payors, and where other factors such as location, physician affiliation, and the perceived quality of the institution are more likely to affect competition than price. See Motion for Summary Judgment (#804), Exhibit #8, Affidavit of Harold M. Ting at 9; Exhibit #120, at 17. Although it is no doubt true that being perceived as an "indigent hospital" negatively affected UMC's ability to attract commercially-insured patients, the facts also clearly demonstrate that this did not deter UMC from actively pursuing and providing services to them. See *supra* at 34-35; Reply (#841), Supplemental Affidavit of Barry C. Harris, Exhibit N, at 14-16; Supplemental Affidavit of Harold M. Ting, Exhibit Z, at 17-21; *see also Rockford Memorial Corp.*, 717 F. Supp. at 1284-85 (N.D. Ill. 1990); *Nonprofit Hospital Mergers: Proceed With Caution*, 20 Cumb. L. Rev. 719, 720-28 (1989-90) (describing generally the market forces which cause nonprofit hospitals to compete with for-profit hospitals). To argue that UMC, the second largest acute care hospital in Clark County, was entirely removed from the competitive market for hospital services because it was perceived by some as a "county hospital" which also served indigent patients simply ignores the competitive reality of the Clark County hospital market.

This Court concludes that, based on the record in this case, the Antitrust Class has failed to properly establish either of its proposed submarkets. To the extent a relevant competitive market is defined by the parties, this market would be the general acute care hospital service market in

Clark County consisting of Boulder City, Community, Desert Springs, St. Rose, Sunrise, UMC, Valley, and Women's hospitals.

5. Monopoly Power Within the Relevant Market

Once a relevant market is established, the inquiry shifts to whether the alleged monopolist exercised or had the potential to exercise market power. Although no single factor has been held determinative, the evaluation of market power usually depends on an evaluation of market share and barriers to entry. See *Oahu*, 838 F.2d at 366. A helpful framework for evaluating market share which has been used repeatedly by courts was articulated by Judge Learned Hand in *United States v. Alum. Co. of America*, 148 F.2d 416, 424 (2d Cir. 1945), where he found that a ninety percent market share is enough to constitute a monopoly, a sixty percent market share is doubtful, and "certainly thirty-three percent is not." *Id.*; *Syufy Enterprises v. American Multicinema, Inc.*, 793 F.2d 990, 995 (9th Cir. 1986), *cert. denied*, 479 U.S. 1031, 93 L. Ed. 2d 830, 107 S. Ct. 876 (1987); *Rebel Oil Co., v. Atlantic Richfield Co.*, 808 F. Supp. 1464, 1468 (D. Nev. 1992); *see also Barry*, 805 F.2d at 874; Areeda & Turner, *Antitrust Law*, § 518.3 at 522-523 (1991 Supp.). In addition, declining market share may reflect the absence of market power. Output as opposed to capacity is a more accurate measure of market share, and excess capacity, if it can be reasonably be determined, may limit the exercise of market power. Oahu, 838 F.2d at 366; Carilion, 707 F. Supp. at 848-49; Areeda & Turner, Antitrust Law, §§ 520(a), 521(e) (1991 Supp.).

In determining the market share of hospitals, facts that need to be examined include the percentage shares of patient days and admissions of the various competitors. Facts which are relevant to hospital capacity include the number of licensed beds within the hospitals as well as their respective occupancy percentages. An examination of these facts in the present case reveal the following:

(1) Patient Days - Sunrise's market share of Clark County hospital patients in terms of patient days was 35% in 1985, 33% in 1986, 32% in 1987, and 32% 37 in 1988;[24]

(2) Admissions - Sunrise's market share of Clark County hospital patients in terms of admissions was 34% in 1985, 32% in 1986, 30% in 1987, and 30% in 1988;[25]

(3) Number of Licensed Beds - Sunrise's percentage of licensed beds in Clark County was 36% in 1985, 35% in 1986, 35% in 1987, and 35% in 1988;[26]

(4) Occupancy Percentage - Sunrise's capacity utilization of all beds was 52% in 1985, 48% in 1986, 52% in 1987, and 53% in 1988 compared to a Clark County average utilization

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[24] See Motion for Summary Judgement (#804), Exhibit 7, Affidavit of Barry C. Harris at Exhibit 2a; Reply (#841), Supplemental Affidavit of Barry C. Harris at Exhibit 1.

[25] *Id.*

[26] Reply (#841), Supplemental Affidavit of Barry C. Harris at Exhibit 1.

rate of 53% in 1985, 44% in 1986, 56% in 1987, and 58% in 1988.[27]

As can be seen from the above figures, throughout the relevant time period, Sunrise had approximately one third of the Clark County market for acute care hospital services. Although it is true that at the time in question, Nevada's Certificate of Need requirements acted as a potential entry barrier to new participants, the evidence also demonstrates that during the relevant time period there was substantial excess bed capacity at existing hospitals. This excess capacity would temper any competitive advantage Sunrise might have realized from such regulations.[28]

Accordingly, this Court further finds that Plaintiffs have failed to establish that Defendants had the ability to exercise monopoly power within Clark County's acute care hospital market during the relevant time period. *See Thurman*, 875 F.2d, at 1377-80; *Barry*, 805 F.2d at 874; *Bhan*, 669 F.

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[27] See Motion for Summary Judgment (#804), Exhibit 7, Affidavit of Barry C. Harris at Exhibit 4. Also included in his exhibit are the individual utilization rates of the various individual hospitals in Clark County. These rates are approximately 40% to 60% during the relevant time period.

[28] In fact, an argument could be made that the Nevada's Certificate of Need requirements actually injured Sunrise's competitive position since of the 2415 additional beds which were licensed between 1979 and 1988, only 16 of these were given to Sunrise. See Reply (#242), Supplemental Affidavit of Harold M. Ting, Exhibit Z, at Exhibit 5.

Supp. at 1022-23.[29] Using only Desert Springs, Sunrise, Valley, and UMC as the competitive market, in total patient days Humana had market shares of 40% in 1985, 38% in 1986, 36% in 1987, and 36% in 1988 and in admissions Humana had market shares of 38% in 1985, 39% in 1986, 36% in 1987, and 35% in 1988. See Opposition (#820), Exhibit 107 (data relating to inpatient days and admissions for Desert Springs, Sunrise, Valley, and UMC).

6. Antitrust Injury

Finally, even if this Court could find that Plaintiffs have adequately defined a relevant competitive market and have shown Defendants monopolized or attempted to monopolize that market, this Court would nevertheless have to conclude that Plaintiffs have not adequately demonstrated antitrust injury. Although Plaintiffs claim that they have suffered antitrust injury as a result of paying excessive premiums and/or co-payments, such monetary losses relate, if at all, to Defendant Humana Insurance's allegedly erroneous interpretation of the health insurance contract, and not the alleged anti-competitive acts of Sunrise (e.g. the diversion of critical care patients and refusal to unbundle level III neonatal services). This, coupled with the fact that Plaintiffs were only indirect purchasers of hospital services whose

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[29] Even if this Court were to assume that the smaller hospitals in Clark County were not within the same competitive market as Sunrise, such a fact does not alter the conclusion that Sunrise did not have sufficient market share within Clark County to exercise market power during the relevant time period.

premiums and co-payments were undoubtedly subject to a number of other influences (e.g. competition in the health insurance market, state regulation, etc.) external to the cost of hospital services, clearly demonstrates that Plaintiffs' Antitrust Class has not suffered "antitrust injury." *Cf. Austin*, 903 F.2d at 1390-93.

C. Conclusion

In light of Plaintiffs' failure to adequately demonstrate the alleged submarkets, the fact that Defendants could not exercise market power, and the failure of Plaintiffs to demonstrate antitrust injury, Defendants are entitled to summary judgment on Plaintiffs' Second Claim for Relief.

IV. RICO

A. Overview

The Third and final Claim for Relief alleged by Plaintiffs in their Second Amended Complaint is a violation of RICO pursuant to 18 U.S.C. § 1964(c) brought by Plaintiffs Co-Payor Class and Premium Payor Class. In support of this claim, both classes of Plaintiffs assert that during 1985 to 1988: (1) Humana and Humana Insurance acted as members of an "association in fact" enterprise or, alternatively, that Humana, a person within the meaning of 18 U.S.C. § 1964(3), associated with Humana Insurance, an enterprise within the meaning of 18 U.S.C. § 1961(4); (2) that Humana and Humana insurance entered into a secret agreement to discount amounts owed by Humana Insurance for hospital charges incurred by Humana Insurance insureds; (3) Humana and Humana Insurance concealed and/or misrepresented this agreement to Plaintiffs in the numerous

mailings, telephone calls, and television/radio advertisements; and (4) that such acts (a) were intended to and did induce the Premium Payor Class into buying policies they would not have otherwise purchased, and (b) defrauded the Co-Payor Class into paying excessive co-payments. Second Amended Complaint (#370) at 18, 22-23; Errata (#822) at 103-109, 221-223, 251-253.

In support of their Motion for Summary Judgment (#804), Defendants Humana and Humana Insurance assert the following arguments:

(1) Plaintiffs cannot prove that the alleged misrepresentations and/or omissions of Defendants were intended to defraud them since (a) it is undisputed that the Humana Insurance policy mirrored other health plans in place during the relevant time period and, (b) the discount arrangement was disclosed to Nevada regulators. Motion for Summary Judgment (#804) at 98-116;

(2) New precedent requires this Court to reverse its prior ruling that Humana is a "person" distinct from Humana Insurance, the "enterprise," under 18 U.S.C. § 1962(c). Motion for Summary Judgment (#804) at 131-136;

(3) The Premium Payor Class cannot show that they suffered RICO injuries, or even assuming they could, that these injuries were proximately caused by Defendants' actions. Motion for Summary Judgment (#804) at 116-126; (4) Under RICO, the only damages which the Co-Payor Class is entitled to recover is the amount of excess co-payments which the class paid as a result of Defendants' allegedly improper interpretation of the policy. Motion for Summary

Judgment (#804) at 126-131; (5) The McCarran-Ferguson Act Precludes Plaintiffs' RICO cause of action. Motion for Summary Judgment (#804) at 136-146.

B. Requirements of RICO, 18 U.S.C. § 1962(c)

Liability pursuant to 18 U.S.C. § 1962(c) requires a Plaintiff to demonstrate (1) the conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity. *Sun Savings and Loan Assoc. v. Dierdorff*, 825 F.2d 187, 191 (9th Cir. 1987). "Racketeering activity" is any act indictable under various provisions of Title 18 of the United States Code, see 18 U.S.C. § 1961, and includes the predicate acts alleged in this case of mail fraud and wire fraud pursuant to 18 U.S.C. §§ 1341, 1343. *Id.*

In order to commit mail fraud under § 1341, Plaintiffs must demonstrate that: "(1) the defendants formed a scheme or artifice to defraud: (2) the defendants used the United States mails or caused a use of the United States mails in furtherance of the scheme; and (3) the defendants did so with the specific intent to deceive or defraud." *Schreiber Distributing v. Serv-Well Furniture Co.*, 806 F.2d 1393, 1400 (9th Cir. 1986). Similarly, in order to commit wire fraud pursuant to § 1343, Plaintiffs must show: "(1) the formation of a scheme or artifice to defraud; (2) the use of the United States wires or causing a use of the United States wires in furtherance of the scheme; and (3) specific intent to deceive or defraud." *Id.*

Under these provisions, fraud refers to "'(1) a false representation (2) in reference to a material fact (3) made with knowledge of its falsity (4) and with the intent to

deceive.'" *United States v. Bonallo*, 858 F.2d 1427, 1433 (9th Cir. 1988). A failure to disclose or concealment may also serve a basis for a fraudulent scheme under mail and wire fraud statutes; however, such nondisclosure must arise from a failure to comply with an independent statutory or fiduciary duty. *California Arch. Bldg. Prods. v. Franciscan Ceramics*, 818 F.2d 1466, 1472 (9th Cir. 1987), *cert. denied*, 484 U.S. 1006, 98 L. Ed. 2d 650, 108 S. Ct. 698 (1988); *United States v. Dowling*, 739 F.2d 1445, 1449 (9th Cir. 1984), *rev'd on other grounds*, 473 U.S. 207, 87 L. Ed. 2d 152, 105 S. Ct. 3127 (1985).

C. Plaintiffs' Failure to Demonstrate Intent to Defraud

The first argument raised by Defendants in support of their Motion for Summary Judgment (#804) on Plaintiffs' RICO claims is that there is no evidence to suggest that Defendants had "specific intent to deceive or defraud" the Plaintiffs. More specifically, Defendants contend that insofar as the development of the policy in question is concerned:

(1) during the period in question, the health care industry was just beginning to experiment with preferred provider arrangements, and no industry standards were in place governing how co-payment discounts should be administered; (2) that the policy in question was simply modeled after one developed and already in place in Florida; (3) Medicare employs an analogous system for the payment of co-payments; (4) confidentiality clauses were common in the industry for such discount arrangements to ensure the protection of proprietary information; and (5) that only 9.54% of all Humana Insurance insureds resulted in paying

higher co-payments if the discount given Humana Insurance would have been shared.

Motion for Summary Judgment (#804) at 99-108.

Defendants further assert that various parties other than Defendants were aware of the co-payment arrangement, that Defendants disclosed the discount arrangement to Nevada regulators at various times between 1984 and 1986, and that on June 6, 1986, while at hearings before the Nevada Department of Insurance ("DOI"), Defendants directly informed DOI officials that bills issued to insureds did not reflect any discounts received by Humana Insurance from Humana. Motion for Summary Judgment (#804) at 110-116.

Plaintiffs respond that notwithstanding any disclosures made by Defendants to third parties, Defendants failed to disclose the co-payment scheme to Plaintiffs directly, and even had attempted to conceal it. According to Plaintiffs, Defendants' Motion for Summary Judgment (#804) raises a material question of fact regarding whether Defendants had the requisite "intent" required under the mail and wire fraud statutes. See Errata (#822) at 146, 219-221.

In determining whether Defendants satisfy the "intent" requirement of the mail and wire fraud statutes, Plaintiffs must demonstrate that the fraud was active and not merely constructive. *United States v. Bohonus*, 628 F.2d 1167, 1172 (9th Cir. 1980), *cert. denied*, 447 U.S. 928, 65 L. Ed. 2d 1122, 100 S. Ct. 3026 (1980). Specific intent may be shown by examining the scheme to determine whether it "was reasonably calculated to deceive persons of ordinary prudence and comprehension." *Sun Savings*, 825 F.2d at

196; *Schreiber*, 806 F.2d at 1400; *Bohonus*, 628 F.2d at 1172; *see also United States v. Green*, 745 F.2d 1205, 1209 (9th Cir. 1984), *cert. denied*, 474 U.S. 925, 88 L. Ed. 2d 266, 106 S. Ct. 259 (1985) (specific intent to defraud means to deceive or mislead, and does not include situations where act involved was the result of ignorance, mistake, or accident).

Notwithstanding the facts asserted by Defendants, viewing all inferences in favor of Plaintiffs as this Court must do, it is clear that a material question of fact exists as to whether Defendants' interpretation of the co-payment provision, which was furthered through the use of United States mails or wires, was specifically intended to mislead or deceive Plaintiffs or whether it was the result of ignorance, mistake, or accident. Accordingly, Defendants Motion for Summary Judgment (#804) on this ground must be denied.

D. Person/Enterprise Distinction

Plaintiffs next allege that Humana and Humana Insurance acted as members of an "association in fact" enterprise or, alternatively, that Humana, a person within the meaning of 18 U.S.C. § 1964(3), associated with Humana Insurance, an enterprise within the meaning of 18 U.S.C. § 1961(4), to defraud Plaintiffs. As this Court recognized in its July 9, 1991 Order (#364), such allegations satisfy the "person/enterprise" requirements of U.S.C. § 1962(c). *See River City Markets v. Fleming Foods West*, 960 F.2d 1458, 1460-62 (9th Cir. 1992); *U.S. v. Feldman*, 853 F.2d 648, 656-59 (9th Cir. 1988), *cert. denied*, 489 U.S. 1030, 103 L. Ed. 2d 222, 109 S. Ct. 1164 (1989); *cf. Glessner v. Kenny*, 952 F.2d 702, 710-14 (3rd Cir. 1991). Accordingly,

Defendants are not entitled to summary judgment on this ground.

E. RICO Damages for the Premium Payor Class

The third argument asserted by Defendants in support of summary judgment is that the Premium Payor Class has not demonstrated the requisite causal nexus between the RICO damages they seek and the fraud alleged as a predicate act. This Court agrees.

At the outset, the Premium Payor Class notes that the nondisclosure of the discounting arrangement between Humana and Humana Insurance induced its members into obtaining Humana Insurance policies. Errata (#822) at 221-222. The Premium Payor Class then asserts that numerous television and direct mail advertisements promised that employers and employees would "share in reduced hospital costs through premium reductions." Errata (#822) at 104, 222, 235.[30] The damages which the Premium Payor

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[30] The language from the advertisements to which the Premium Payor Class refer is as follows:

(1) "Tap Dance" commercial: "Because we can control costs, both you and your company can save a great deal of money without the song and dance;"
(2) "Mumbo Jumbo" commercial: "We can save you and your company money without insurance mumbo jumbo;"
(3) "Cuts" commercial: "Humana is a hospital company, so we can control costs,
saving employers and employees money."

Class contend they have suffered as a result of these actions is "the difference in the actual price of the insurance product that they purchased (the premiums actually paid) and what the premiums should have been if premiums were calculated to include the discounts that Humana Insurance was receiving." Errata (#822) at 222.

In *Imagineering, Inc. v. Kiewit Pacific Co.*, 976 F.2d 1303 (9th Cir. 1992), *cert. denied*, 123 L. Ed. 2d 266, 113 S. Ct. 1644 (1993), the Ninth Circuit clarified the requirements of proximate causation and recoverable damages under RICO. With respect to the issue of proximate causation, the Court in Imagineering stated:

> In order to maintain a cause under RICO then, the plaintiff must show not only that the defendant's violation was a "but for" cause of his injury, but that it was the proximate cause as well. This requires that there must be a direct relationship between the injury asserted and the injurious conduct alleged. . . . One principle underlying this requirement is that the less direct the injury is, the more difficult it becomes to ascertain the amount of a plaintiff's damages attributable to the violation, as distinct from other, independent factors.

Id. at 1311, citing *Holmes v. Securities Investor Protection Corp.*, 117 L. Ed. 2d 532, 112 S. Ct. 1311, 1317-18 (1992). Consistent with this view of proximate cause, the Court in

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Errata (#822) at 33; Reply (#841) at 35.

Imagineering held that not all injuries are compensable under RICO, but rather only those which are proven by a "concrete financial loss." *Id.* at 1310; *see also Oscar v. University Students Co-operative Ass'n*, 965 F.2d 783, 785 (9th Cir. 1992) (*en banc*), *cert. denied*, 121 L. Ed. 2d 581, 113 S. Ct. 655 (1992).

The claim by the Premium Payor Class that Humana Insurance's advertising campaign misrepresented that its members would "share in reduced hospital costs through premium reductions," is without merit. The advertisements to which Plaintiffs refer are nothing more than puffery and plainly do not contain any representations which would indicate how insurance premiums would be calculated. As such, this alleged predicate act cannot be viewed as the proximate cause of the Premium Payor Class' asserted RICO injury. *See, e.g., Berent v. Kemper Corp.*, 973 F.2d 1291, 1295-96 (6th Cir. 1992).

The Premium Payor Class also argues that had its members known how Humana Insurance would calculate co-payments under its policy, they would not have purchased Humana polices. This argument is problematic for several reasons.

First, as stated by Defendants, the logical injury which would follow from a "fraudulent inducement" would be that the Premium Payor Class could have obtained comparable policies elsewhere for less and instead chose Humana as their insurance carrier. See Reply (#841) at 36-37. Plaintiffs do not present any evidence in this regard. See Errata (#822) at 227-236.

Plaintiffs argue instead that they did not get the benefit of what they bargained for: an insurance policy under which co-payments would be calculated with consideration of any hospital discounts received. See Errata (#822) at 224. Plaintiffs may be correct, although there is no evidence in the record to demonstrate that they are. Unlike the Co-Payor Class, however, the members of the Premium Payor Class never incurred a hospital bill or made a co-payment. Its members simply paid the premiums they had previously agreed to pay assuming that any hospital discounts obtained by Humana Insurance would be reflected in their co-payment determinations. Accordingly, even though it is clear that the members of the Premium Payor class could have *potentially* been defrauded by Defendants' calculation of co-payments, under the undisputed facts, no such injury actually occurred.

Plaintiffs' additional argument that their "injury" arose from the fact that Sunrise's discount to Humana Insurance should have been included in calculating their initial premiums must be rejected for two reasons. First, although this argument enables Plaintiffs to state a more direct injury, it completely ignores the fact that the fraud which supposedly induced Plaintiffs to purchase the Humana policy involved representations about how co-payments were to be determined. Nothing in the record suggests that the Defendants fraudulently represented how they would calculate premiums.[31] Even if Humana Insurance did err in

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[31] Indeed, Plaintiffs indirectly acknowledge this point in their Opposition when they admit that their argument is not that "Defendants' fraud 'caused' Defendants to charge improper premiums." See Errata (#822) at 224.

its calculation of the initial premiums, this error was independent of the predicate acts which Plaintiffs have alleged throughout this litigation.

Second, Plaintiffs' argument ignores other factors, such as the price of competing insurance products, that were used to determine the price of premiums paid by the Premium Payor Class. See Errata (#822) at 228. Assuming that simply deducting the cost of the discounts in Defendants' actuarial formula would lead to a fair market price that the Premium Payor Class would have paid for the Humana policy ignores the competitive realities of the group health insurance market.

Accordingly, given the failure of the Premium Payor Class to adequately demonstrate a "direct relationship between the injury asserted and the injurious conduct alleged" or a "concrete financial injury" for purposes of RICO, Defendants are entitled to summary judgment. *Imagineering*, 976 F.2d at 1311.

F. RICO Damages for the Co-Payor Class

This Court previously has analyzed how to calculate the damages incurred by the Co-Payor Class which would be causally connected to Defendants' alleged breach of fiduciary duties under ERISA. *See supra* at 1507-09. This Court finds that the reasoning of the Ninth Circuit in *Imagineering* and *Oscar* regarding the requirements of proximate cause and concrete financial injury applies with equal force in the context of damages available under RICO. Accordingly, Defendants are entitled to summary judgment on the Co-Payor Class' RICO claim to the extent that the Co-Payor

Class seeks damages in excess of the amount that they could have recovered under a proper interpretation of the co-payment provision.

G. McCarran-Ferguson Act Exception

Finally, Defendants argue that the McCarran-Ferguson Act precludes Plaintiffs from pursuing their RICO claim. This Court agrees.

Section § 1012(b) of the McCarran-Ferguson Act provides:

> No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . unless such Act specifically relates to the business of insurance. . . .

15 U.S.C. § 1012(b).

The purpose of this provision is to impose a clear-statement rule "that state laws enacted 'for the purpose of regulating the business' do not yield to conflicting federal statutes unless a federal statute specifically requires otherwise." *United States Dept. of the Treasury v. Fabe*, 124 L. Ed. 2d 449, 113 S. Ct. 2202, 61 U.S.L.W. 4579, 4583 (1993) (citation omitted).

In order to determine if Section 2(b) precludes application of a particular federal statute, a court must apply the following four part test: (1) is the federal statute one which specifically relates to the business of insurance; (2) does the complained of activity constitute the business of insurance; (3) has the state enacted laws for the purpose of

regulating the complained of activity; and (4) would the application of the federal statute invalidate, impair, or supersede the state legislation. *See LeDuc v. Kentucky Central Life Ins. Co.*, 814 F. Supp. 820, 826-27 (N.D. Cal. 1992); *Thacker v. New York Life Ins. Co.*, 796 F. Supp. 1338, 1341 (E.D. Cal. 1992).

There can be no dispute that RICO does not specifically relate to the business of insurance. *See LeDuc*, 814 F. Supp. at 827; *Thacker*, 796 F. Supp. at 1341.

It is equally clear that Plaintiffs' complained of activities constitute the "business of insurance." The crux of the RICO claim brought by the Premium Payor Class is that nondisclosure of the discount arrangement between Humana and Humana Insurance in advertisements and other communications fraudulently induced its members into purchasing the Humana Insurance policies. See Second Amended Complaint (#370) at 18-23. The gravamen of the RICO claim brought by the Co-Payor Class is that nondisclosure of the discount arrangement between Humana and Humana Insurance fraudulently induced its members into paying excessive co-payments. *Id.* Since these alleged acts directly relate to the purchase and execution of Humana Insurance policies, they fall squarely within the meaning of the "business of insurance." *See Fabe*, 61 U.S.L.W. at 4582 ("the actual performance of an insurance contract falls within 'the business of insurance'. . . to hold otherwise would be mere formalism."); *WEXCO, Inc. v. IMC, Inc.*, 820 F. Supp. 194 (M.D. Pa. 1993); *LeDuc*, 814 F. Supp. at 828; *but see, Thacker*, 796 F. Supp. at 1342. Accordingly,

Defendants also satisfy the second prong of the McCarran-Ferguson test.

In evaluating whether Nevada has enacted laws governing the activities complained of in Plaintiffs' RICO claims, it is not necessary that a state have a specific statute banning a particular practice. The inquiry is whether the state involved has adopted a regulatory scheme which possesses jurisdiction over the challenged activity. *See Feinstein v. Nettleship Co. of Los Angeles*, 714 F.2d 928, 933 (9th Cir. 1983), *cert denied*, 466 U.S. 972, 80 L. Ed. 2d 820, 104 S. Ct. 2346 (1984); *WEXCO*, 820 F. Supp. at 197.

In 1971, Nevada adopted the Trade Practices and Frauds; Financing of Premiums Act ("Act"), N.R.S. § 686A.010, *et seq.* This Act was designed to regulate the business of insurance as recognized in the McCarran-Ferguson Act "by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined and determined." N.R.S. § 686A.010. Under this Act, Nevada recognized that the Commissioner of Insurance "has exclusive jurisdiction" in regulating the trade practices of the business of insurance. N.R.S. § 686A.015. Furthermore, the Act specifically prohibits the dissemination of false or misleading information relating to the sale of policies or the benefits obtained thereto, N.R.S. §§ 686A.030, 686A.040, and those violating the Act are subject to enforcement of its provisions by the Commissioner. N.R.S. §§ 680A.200, 686A.160, 686A.170,

and 686A.310. These statutes and others requiring the approval of forms used by insurers, N.R.S. §§ 687B.120, 687B.130, clearly demonstrate an attempt by Nevada to regulate the conduct complained of in this case through the adoption of a comprehensive regulatory scheme.[32] Accordingly, this Court finds that the third prong of McCarran-Ferguson test is also satisfied. *See also WEXCO*, 820 F. Supp at 197; *LeDuc*, 814 F. Supp. at 829; *Thacker*, 796 F. Supp at 1341-42.

Finally, under the McCarran-Ferguson test, this Court must consider whether the application of RICO would invalidate, impair, or otherwise supersede Nevada legislation. As acknowledged by Plaintiffs in their Opposition (#822), the Nevada Commissioner of Insurance, in enforcing the Act, can prohibit unfair trades practices, impose fines, and withdraw approval of insurance plans. See Opposition (#822) at 270-274; N.R.S. §§ 686A.160, 686A.170, 686A.187, and 687B.130. As Plaintiffs contend, the State of Nevada does not proscribe the same harsh penalties which would be available under RICO (e.g. treble damages and attorney's fees) for Defendants' violation of unfair trade practices. See Errata (#822) at 270-274. As recognized by the courts in *WEXCO* and *LeDuc*, however, this is the very

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[32] In fact, Plaintiffs tacitly admit that Humana Insurance's fraudulent activity was covered by the existing Nevada statutory scheme when they argue that Humana Insurance "cavalierly ignored" these "general legal requirements," thus requiring the Nevada legislature to pass in 1987 the more rigorous requirements of sharing discounts under AB 289. See Opposition (#822) at 271.

reason why the fourth prong of the McCarran-Ferguson test is met. *See WEXCO* 820 F. Supp. at 198; *LeDuc*, 814 F. Supp at 829; *but see Thacker*, 796 F. Supp at 1343. For this Court to allow Plaintiffs to pursue the harsher RICO penalties for behavior which the Nevada Legislature apparently did not deem worthy of such penalties, would be tantamount to allowing Congress to intercede in an area expressly left to the states under the McCarran-Ferguson Act. Accordingly, this Court also finds that the fourth prong of the McCarran-Ferguson analysis is satisfied.[33]

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[33] At oral argument, Plaintiffs for the first time argued that since Defendants' conduct could arguably be sanctioned under Nevada's RICO statute, N.R.S. @ 207.470, the harsh remedies afforded by the federal RICO statute cannot be seen to displace or supersede existing Nevada law. This Court disagrees.

As recognized earlier in this Order, Plaintiffs could not pursue a Nevada RICO claim in this case given the fact that ERISA preempts such a claim. *See supra* at __. Beyond this, it is clear that in adopting the Act, the Nevada legislature intended the Insurance Commissioner to have "exclusive jurisdiction" over fraudulent insurance practices. See N.R.S. @ 686A.015. This, combined with the fact that the Nevada legislature specifically identified fraud on the part of the insured and not by the insurer as a possible predicate act under N.R.S. @ 207.470, demonstrates an intent of the Nevada legislature to limit the amount of damages recoverable against an insurer for fraud. *See* N.R.S. @@ 207.360(30), 680A.200, 686A.160, 686A.170, 686A.290, 686A.291, and 686A.310.

This Court, therefore, concludes that the RICO claims alleged by the Premium Payor Class and the Co-Payor Class are barred by the McCarran-Ferguson Act. In doing so, the Court recognizes that Plaintiffs may view the interplay between the McCarran-Ferguson Act and ERISA as posing a preemptive "Catch-22," with McCarran-Ferguson precluding Plaintiffs' federal RICO claim and ERISA barring Plaintiffs' state RICO claim. The result is not entirely anomalous, however, given that Congress has occupied the field through ERISA by which certain well-defined remedies have been provided and others excluded.

V. ORDERS

IT IS THEREFORE ORDERED that Defendants' Motion for Summary Judgment (#804) is Granted to the extent that Judgment is hereby entered in favor of Defendants and against Plaintiffs as to Plaintiffs' First, Second, and Third Claims for Relief.

IT IS FURTHER ORDERED that Plaintiffs' Co-Payor Class only shall have to and including August 24, 1993, within which to file a Third Amended Complaint seeking relief on Plaintiffs' First Claim for Relief pursuant to 29 U.S.C. § 1132(a)(1)(B), consistent with Part II of this Memorandum Decision.

DATED: July 21, 1993

PHILIP M. PRO
United States District Judge

APPENDIX C
(Relevant Statutory Provisions)

McCarran-Ferguson Act, 15 U.S.C. § 1012(b):

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1962:

> (a) It shall be unlawful for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity or through collection of an unlawful debt in which such person has participated as a principal within the meaning of section 2, title 18, United States Code, to use or invest, directly or indirectly, any part of such income, or the proceeds of such income, in acquisition of any interest in, or the establishment or operation of, any enterprise which is engaged in,

or the activities of which affect, interstate or foreign commerce. A purchase of securities on the open market for the purposes of investment, and without the intention of controlling or participating in the control of the issuer, or of assisting another to do so, shall not be unlawful under this subsection if the securities of the issuer held by the purchaser, the members of his immediate family, and his or their accomplices in any pattern or racketeering activity or the collection of an unlawful debt after such purchase do not amount in the aggregate to one percent of the outstanding securities of any one class, and do not confer, either in law or in fact, the power to elect one or more directors of the issuer.

(b) It shall be unlawful for any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise engaged in , or the activities which affect, interstate or foreign commerce.

(c) It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

(d) It shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b), (c) of this section.

Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1964:

(a) The district courts of the United States shall have jurisdiction to prevent and restrain violations of section 1962 of this chapter by issuing appropriate orders, including, but not limited to: ordering any person to divest himself of any interest, direct or indirect, in any enterprise; imposing reasonable restrictions on the future activities or investments of any person, including but not limited to, prohibiting any person from engaging in the same type of endeavor as the enterprise engaged in, the activities of which affect interstate or foreign commerce; or ordering dissolution or reorganization of any enterprise, making due provision for the rights of innocent persons.

(b) The Attorney General may institute proceedings under this section. Pending final determination thereof, the court may at any time enter such restraining orders or prohibitions, or take such other actions, including the acceptance of satisfactory performance bonds, as it shall deem proper.

(c) Any person injured in his business or property by reason of a violation of section 1962 of this

chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee.

(d) A final judgment or decree rendered in favor of the United States in any criminal proceeding brought by the United states under this chapter shall estop the defendant from denying the essential allegations of the criminal offense in any subsequent civil proceeding brought by the United States.

(2)

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No. 97-303

In The

Supreme Court of the United States

October Term, 1996

HUMANA, INC., AND HUMANA HEALTH INSURANCE OF NEVADA, INC.,

Petitioners,

v.

MARY FORSYTH, MARIETTA CADE, WILLIE ANDREWS, MARY LOU BUEHLER, HELEN STAVES, RANDOLPH BRATTON, AND SEARLE AUTO GLASS, INC.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

RESPONDENTS' OPPOSITION TO HUMANA'S PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether this Court should grant the Petition for Writ of Certiorari submitted by Humana, Inc. and Humana Health Insurance of Nevada, Inc., which asks this Court to decide whether the application of RICO anti-fraud provisions to insurance kickback schemes is pre-empted by the McCarran-Ferguson Act, when the inter-circuit split is negligible and insufficiently developed, and the only Court of Appeals cases deeming RICO pre-empted by McCarran-Ferguson are wrongly and inadequately reasoned or squarely conflict with this Court's bedrock pre-emption jurisprudence.

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OPINION BELOW

The Ninth Circuit Court of Appeals' decision in this case is reported as *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997) (withdrawing and superseding its own decision in *Forsyth v. Humana, Inc.*, 99 F.3d 1504 (9th Cir. 1996)). The District Court's opinion, also entitled *Forsyth v. Humana, Inc.*, is found at 827 F. Supp. 1498 (D.Nev. 1993). The decisions of both courts are included in the petition for certiorari of the Petitioners.

JURISDICTION

The decision upon which Petitioners seek review was entered by a panel of the Ninth Circuit Court of Appeals on May 23, 1997. Humana, Inc., and Humana Health Insurance of Nevada, Inc., (hereinafter, "Petitioners") submitted a Petition for Writ of Certiorari to this Court on August 18, 1997. This Court has jurisdiction to review that decision as stated therein by Petitioners. Respondents bring this Opposition to Humana's Petition for Writ of Certiorari pursuant to Rule 15 of the Rules of the Supreme Court of the United States.

The Ninth Circuit Court of Appeals exercised jurisdiction under 28 U.S.C. § 1291. The district court had jurisdiction over this Class Action pursuant to 28 U.S.C. § 1331.

STATUTES AT ISSUE

This Opposition concerns the Racketeer Influenced and Corrupt Organizations Act (RICO) 18 U.S.C. § 1951 et seq., and section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b). Relevant portions of RICO and the McCarran-Ferguson Act are included within Appendix C of Humana's Petition for Writ of Certiorari.

STATEMENT OF THE CASE[1]

84,000 Nevada citizens and business entities brought this class action suit as a result of billing fraud and false representations in advertisements by their health insurance provider, Humana Health Insurance, Inc,[2] and Antitrust violations by Humana, Inc., owner of a chain of hospitals including Humana Hospital Sunrise in Las Vegas, Nevada.[3] Humana, Inc., has since merged with Columbia/HCA, who petitioners concede is beneficially interested.

Humana Insurance sold employee group health care insurance policies to the class. The typical policy was based on an 80%/20% co-pay system by which

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[1] Portions of this Statement of the Case outlining the general background of this litigation are reproduced in the Statement of the Case in Respondents' Conditional Cross-Petition for Writ of Certiorari filed concurrently herewith.

[2] Hereinafter, "Humana Insurance."

[3] Collectively referred to as the "Humana defendants."

the insured would pay 20% of any hospital bill incurred at Humana Hospital Sunrise, and the remaining balance would be satisfied by Humana Insurance. In reality, Humana Insurance negotiated a secret 89% discount with Humana Hospital. To conceal this discount, Humana Insurance remitted payment for 80% of the full, non-discounted hospital bill via check to Humana Hospital and, in turn, Humana Hospital would "kickback" approximately 89% of that payment to Humana Insurance through a monthly, inter-company ledger transfer. Accordingly, a hypothetical $1,000 Humana Hospital bill would result in payment of $200 by the patient, and roughly $100 by Humana Insurance, instead of the contractually agreed upon amount of $800. The patient did not receive any part of the secret discount and paid 20% of the full bill.

In the mid-1980's, Humana Insurance launched a television commercial and direct mail campaign targeting thousands of employers, whereby it represented: "Humana is a hospital company, so we can control costs, saving employers and employees money," and "[b]ecause we can control costs, both you and your company can save a great deal of money without the song and dance." SEC disclosures filed by Humana made similar promises, professing that the health insurance plans were "designed to encourage patients to obtain necessary care in Humana hospitals, where savings could be shared with employers and their employees through lower premiums."

In the mid to late 1980's, at the height of this scheme, Humana Hospital Sunrise was the most expensive hospital in Nevada. The State of Nevada

ranked first in the United States in hospital profitability. In 1986, Humana Hospital Sunrise experienced a 42.2% return on investment, contrasting sharply with the 10.3% hospital national average. Humana Hospital Sunrise held many health care cost records from 1986-88, charging the highest amount per patient, earning the highest revenue per patient, and realizing an average $1,363.00 profit every time a patient was admitted.

The Respondents consist of two classes of insureds: those who made only health insurance premium payments (Premium Payors), and those who also made co-payments for medical treatment (Co-Payors). Together, they asserted claims based on ERISA, RICO, and Section 2 of the Sherman Act. Although the district court granted summary judgment on several aspects of these claims, the pre-emption of RICO by the McCarran-Ferguson Act is the only subject of Humana's Petition and this Opposition.

The Humana Defendants moved the district court for summary judgment on the ground that application of RICO to the fraudulent billing practices alleged here was pre-empted by Section 2 of the McCarran-Ferguson Act, arguing that the plaintiff class was limited to state remedies and that no state remedy existed for their damages. The district court embraced the defendants' argument, agreed that all four prongs of the McCarran-Ferguson test were satisfied, and granted the defendants' motion.

The Ninth Circuit reversed based upon the disharmony of the district court's decision with well-reasoned precedent of this Court and other courts of

appeals. The panel concluded that RICO did not impair or conflict with Nevada's insurance laws in violation of the McCarran-Ferguson Act because each statutory scheme permitted a plaintiff to recover for his or her injuries.

The Humana defendants argue that two recent circuit court decisions reached conclusions contrary to that of the Ninth Circuit panel in the instant case and this asserted conflict requires this Court to resolve the issue. In reality, there is no conflict or minimal conflict. However, in the event that this Court rejects Respondents' arguments and elects to hear this case, Respondents have filed, concurrently herewith, in the alternative and under separate cover, a Conditional Cross-Petition for Writ of Certiorari pursuant to Rule 12.5 of the Rules of this Court.

REASONS FOR DENYING HUMANA'S PETITION

Humana represents that an inter-circuit split in the treatment of the pre-emption of RICO claims by the McCarran-Ferguson Act so cleaves the law in this regard that reconciliation by this Court is necessary. This is simply not true.

The inter-circuit split identified by Humana springs solely from a recent misinterpretation of precedent by the Sixth and Eighth Circuits.[4] Only two

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[4] Petitioner contends that the Fourth Circuit's position agrees with that of the Sixth and Eighth Circuits. Nevertheless, the Fourth Circuit's opinion lacks an

decisions have arguably failed to understand this Court's pre-emption decisions. Hence, this purported inter-circuit rift is not yet sufficiently developed to warrant this Court's precious attention. Moreover, an examination of the decisions proffered by Petitioners as disharmonic with the conclusion reached by the Court of Appeals in the instant case reveals that no real, supported conflict worthy of this Court's present resolution exists.

Petitioner first cites *Doe v. Norwest Bank Minn.*, 107 F.3d 1297, 1306-08 (8th Cir. 1997). The *Doe* court mistakenly adopted a broad reading of the fourth prong of the McCarran-Ferguson Act (MFA) and found an impairment because "the extraordinary remedies of RICO would frustrate, even supplant, [the state's] carefully developed scheme of [insurance] regulation," by permitting the recovery of treble damages and attorneys fees in a private action where state law only provided for administrative relief. This decision ignores clearly contrary precedent of this Court as well as the legislative intent and express language of the RICO statutes.

Since the inception of the RICO statutes, the Congress, this Court and the Courts of Appeal have consistently required that RICO, a remedial statute, be broadly interpreted. *Sedima S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 491 n.16, 497-98 (1985); *United States v. Ginsburg*, 773 F.2d 798, 802 (7th Cir. 1985) (quoting Pub. L. No. 91-452, § 904(a), 84 Stat. 947, and stating

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independent analysis of the issue and therefore, is hardly the mature, final word of the circuit.

that RICO must be "liberally construed to effectuate its remedial purposes.") *cert. denied*, 475 U.S. 1011 (1986). In contrast, Congress intended -- and the courts repeatedly reinforce -- that the MFA must be narrowly construed.[5] *Doe*'s broad construction of the MFA and narrow application of RICO is therefore contrary to established precedent.

Additionally, the *Doe* holding flies in the face of this Court's general pre-emption jurisprudence by ignoring the parallels between federal pre-emption of state laws and state pre-emption of federal laws. "The MFA establishes a form of inverse pre-emption. . . ." Accordingly, basic principles governing federal pre-emption of state law are germane to the analysis of MFA pre-emption. *See Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486, 1492 (9th Cir. 1995), *cert. denied sub nom Brometheus Funding Corp. v. MHDS, Inc.*, 116 S. Ct. 418 (1995); *American Family*, 978 F.2d at 296. This Court's decisions unequivocally reflect the clear teaching that

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[5] *See, e.g.,Stephens v. Nat'l Distillers & Chem. Corp.*, 69 F.3d 1226, 1231 (2d Cir. 1996); *Spirit v. Teachers Ins. & Annuity Ass'n*, 691 F.2d 1054, 1066 (2d Cir. 1982), *vacated on other grounds*, 463 U.S. 1223, 103 S. Ct. 3565, 77 L. Ed. 2d 1406 (1983); *cf. S.E.C. v. Nat'l Sec., Inc.*, 393 U.S. 453, 895 S. Ct. 564, 21 L. Ed. 2d 668 (1969) (stating that the MFA "did not purport to make the states supreme in regulating all the activities of insurance companies," and refusing to interpret the MFA as an "overly broad restriction on federal power"); *NAACP v. American Family Mut. Ins. Co.*, 978 F.2d 287, 294-95 (7th Cir. 1992); *Cochran v. Paco*, 606 F.2d 460, 467 (5th Cir. 1979).

pre-emption be invoked only when there exists a direct clash between a federal law and a state regulation. Additional and different yet non-conflicting remedies are repeatedly held to be not pre-empted.

Silkwood v. Kerr-McGee, 464 U.S. 238, 104 S. Ct. 615, 78 L. Ed. 2d 443 (1984) is the quintessential case in this regard. In *Silkwood*, this Court observed that the proper approach to pre-emption was to consider "whether there is an irreconcilable conflict between the federal and state standards or whether the imposition of a state standard in a damages action would frustrate the objectives of the federal law." *Id.* at 256. That approach in hand, this Court squarely upheld the concurrent imposition of federal fines and state punitive damages for the same tort, rejecting the related argument that the award of punitive damages for radiation hazards was barred because it conflicted with the federal remedial scheme, and finding no conflict between the federal and state laws.[6]

Subsequent opinions of this Court consistently follow the course set by *Silkwood*, and have found pre-emption inapplicable to the concurrent assessment of federal fines and state fraud damage awards for cigarette advertising disclosure violations, *Cipollone v.*

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[6] If this Court can find the application of punitive damages -- *not* directly limited to a multiple of actual damages -- consistent with a parallel remedy of compensatory damages, surely the imposition of federal treble damages -- *limited* by the amount of actual damages -- is not barred by the availability of state actual damages in this case.

Liggett Group, Inc., 505 U.S. 504, 546, 112 S. Ct. 2608, 120 L. Ed. 2d 407 (1992), anti-trust violations, *California v. ARC America Corp.*, 490 U.S. 93, 109 S. Ct. 1661, 104 L. Ed. 2d 86 (1989) (permitting levy of federal treble damages simultaneously with state fraud damages), and medical safety breaches. *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 105 S. Ct. 2371, 85 L. Ed. 2d 714 (1985). Thus, this Court has established beyond question that where "state and federal rules [ ] are substantially identical but differ in penalty, [they] do not conflict with or displace each other." *American Family*, 978 F.2d at 297. Accordingly, the only appropriate holding on the effect of the MFA on RICO's application to health care fraud is that offered by the Ninth Circuit in *Merchants* and the instant case.

The *Doe* decision is also at odds with the legislative purpose reflected in the text of the RICO statutes. *Doe* holds that RICO cannot be applied consistently with state insurance laws under the MFA. "Congress[, however,] enacted RICO in order to supplement, not supplant the available remedies since it thought those remedies offered too little protection for the victim." *Haroco, Inc. v. American Nat'l Bank & Trust Co. of Chicago*, 747 F.2d 384, 392 (7th Cir. 1984), *aff'd*, 473 U.S. 606 (1985). RICO's sanctions and those incorporated by other laws federal and state are, according to the RICO text, to exist side by side. Pub. L. No. 91-452, § 904(a), 84 Stat. 947 (1970); *United States v. Turkette*, 452 U.S. 576, 586 n.9, 101 S. Ct. 2524, 69 L. Ed. 2d 246 (1981) (stating that states are free to exercise power "to the fullest 'extent'"). The existence of such cumulative remedies furthers their remedial purposes. *Herman & McLean v. Huddleston*,

459 U.S. 375, 386, 103 S. Ct. 683, 74 L. Ed. 2d 548 (1983). Any holding that RICO's civil sanctions impair state law is, therefore, squarely inconsistent with RICO's express text.

The second case cited by Petitioner is *Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384 (6th Cir. 1996). *Kenty* is wrongly and inadequately reasoned and it also ignores the relevant case law in the area. The *Kenty* opinion is devoid of any analysis of *Merchants* or *American Family*, the two most highly cited circuit cases on MIFA pre-emption. *Kenty*'s only reference to *Merchants* parenthetically notes only its holding regarding the third prong of the MFA, irrelevant to the resolution of the issue at hand.

Although the *Kenty* court notes its own decision in *Nationwide Mut. Ins. Co. v. Cisneros*, 52 F.3d 1351 (6th Cir. 1995), *cert. denied*, 116 S. Ct. 973 (1996), it mischaracterizes the holding of the case as protective of state laws, when the *Cisneros* court actually concluded, in accordance with *Merchants* and the Ninth Circuit panel in the instant case, "that the presence of additional remedies" in a federal law does not impair the state insurance law at issue. *Cisneros*, 52 F.3d at 1363.

Moreover, *Kenty* may not be sufficiently factually analogous to the instant case to qualify as conflicting. The *Kenty* court based its conclusion partly on its observation that "Ohio law may employ a different standard than the one under RICO to determine when" the statute is violated. *Kenty*, 92 F.3d at 392. If this is the case, the decision is based not on RICO's upset of the balance of the state law and its

intended purpose, but on a direct conflict between the state and federal statutes, and it therefore does not decide the issue raised by this case. *See Dornberger v. Metropolitan Life Ins. Co.*, 961 F. Supp. 506, 518 n.6 (S.D.N.Y. 1997) (rejecting the Eighth Circuit "upset the balance" approach to the fourth prong of the MFA and permitting RICO and state insurance fraud claims to co-exist despite their different penalties.)[7]

Accordingly, as no real inter-circuit conflict exists that warrants this court's resolution, Humana's Petition for Writ of Certiorari must be denied.

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[7] The district court was simply wrong when it held, without textual analysis, that NEV. REV. STAT. § 686A.290, as incorporated in Nevada RICO, located at NEV. REV. STAT. § 207.360(30), which authorizes treble damages under state law, *see* NEV. REV. STAT. § 207.470(1), is not broad enough to include a false statement on an application for insurance made, not only by an insured, but also an insurer. *Forsyth v. Humana, Inc.*, 827 F. Supp. at 1522 n.33; *see* NEV. REV. STAT. § 686A.290 ("other person. . . make false statement . . . with reference to any application"). Accordingly, Nevada law also authorizes treble damages for insurance fraud, except where ERISA pre-empts it. If this analysis is correct, the MFA holding of the Ninth Circuit is not necessarily of general application. Therefore, this Court could, and should, affirm on an independent and adequate state law ground.

CONCLUSION

For the foregoing reasons, Humana's Petition for Writ of Certiorari should be denied. However, should this Court disagree and grant certiorari in this matter, Respondent's Conditional Cross-Petition, filed concurrently herewith, should be granted.

September 12, 1997

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OCTOBER TERM, 1996

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MARY FORSYTH, MARIETTA CADE,
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Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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In The

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Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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REPLY BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

Pursuant to Rule 15.6 of this Court, petitioners Humana Inc. and Humana Health Insurance of Nevada, Inc. submit this brief in reply to Respondents' Opposition To Humana's Petition For Writ of Certiorari ("Opposition").

I. RESPONDENTS' ARGUMENT IN SUPPORT OF THE DECISION BELOW FURTHER ILLUSTRATES THE NEED FOR REVIEW BY THIS COURT.

As is detailed in the Petition for Writ of Certiorari herein, there currently exists a conflict among the circuits respecting the interpretation of the McCarran-Ferguson Act that requires this Court's review and resolution. In their Opposition, Respondents do not contest -- indeed, could not contest -- the existence of the conflict. Respondents attempt to minimize the significance of that conflict, however, by dismissing the circuit court decisions at odds with the decision below here as "spring[ing] solely from a recent misinterpretation of precedent by the Sixth and Eighth Circuits." Opposition at p.5. In particular, respondents urge that the Eighth and Sixth Circuits have failed to apply properly the principles governing federal preemption of state law. Quoting this Court's formulation of the test for implied federal preemption found in *Silkwood v. Kerr-McGee*, 464 U.S. 238 (1984), respondents argue that the decisions of the Sixth and Eighth Circuits do not comport with that test and are, therefore, wrong.

Respondents' argument does not, of course, actually address the question now before this Court: Is there a conflict among the circuits worthy of this Court's time to resolve? Whether it is the Ninth Circuit that is right -- as respondents urge -- or the Sixth and Eighth Circuits -- as petitioners have argued -- is not particularly germane. What is of significance at this stage is the fact that the circuits disagree, regardless of which have it right.

Respondents' argument does, however, point to the depth of the underlying philosophical differences between the circuits that have led to the present conflict. In urging that the Sixth and Eighth Circuits erred in not following the precedents that govern issues of implied federal preemption, respondents necessarily indulge in the threshold presumption that McCarran-Ferguson preemption is to be limited by the same rigorous tests that govern implied federal preemption. The Ninth Circuit and the Seventh Circuit both appear to subcribe to that philosophy, reasoning that the McCarran-Ferguson Act establishes a form of *inverse* preemption of federal law analogous to federal preemption of state law. *See Merchants Home Delivery Serv. Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486, 1492 (9th Cir.), *cert. denied* ___ U.S. ___, 116 S.Ct. 418 (1995); *NAACP v. American Family Mut. Ins. Co.*, 978 F.2d 287, 296 (7th Cir. 1992), *cert. denied* 508 U.S. 907 (1993).

If one does not accept that threshold presumption, the justification for the narrow view of McCarran-Ferguson preemption espoused by the Ninth and Seventh Circuits largely evaporates, and the more flexible analysis favored by the Eighth and Sixth Circuits recommends itself. A key to the differences between the circuits, therefore, is whether the analogy between McCarran-Ferguson and implied federal preemption is as perfect as the Ninth and Seventh Circuits appear to believe. It is not.

The narrow scope of implied federal preemption derives from constitutional notions of federalism. As this Court observed in *Cipallone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992), any assertion of federal

preemption must overcome the strong presumption that Congress did not intend to supersede the historic police powers of the states. No such considerations are present in a McCarran-Ferguson analysis. The McCarran-Ferguson Act does not involve the interference by the federal government in the sovereignty of the states. Rather, it is an express, voluntary relinquishment of power by the federal government. There is no jurisprudential principle that requires that this act of Congress be governed by any rules other than the ordinary principles of statutory construction.

The conflict among the circuits is not attributable to errors in following precedent, as respondents would have it. The conflict reflects a fundamental difference in approach to McCarran-Ferguson, a difference that determines what precedent applies and what does not. The need to resolve that fundamental difference compels review by this Court.

CONCLUSION

For the foregoing reasons, this petition for writ of certiorari should be granted.

September 26, 1997

Respectfully submitted

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No. 97-303

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v.

MARY FORSYTH, ET AL.

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QUESTION PRESENTED

The McCarran-Ferguson Act states that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance * * * unless such Act specifically relates to the business of insurance." 15 U.S.C. 1012(b). The question presented is whether the McCarran-Ferguson Act precludes a private party from bringing suit under the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1964(c) (Supp. I 1995), to obtain a federal remedy for a pattern of fraud allegedly perpetrated by a medical insurer.

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In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-303

HUMANA INC., ET AL., PETITIONERS

v.

MARY FORSYTH, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is filed in response to the Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

The dispute in this case centers on whether the McCarran-Ferguson Act, 15 U.S.C. 1012(b), precludes a private litigant from seeking the civil remedies available under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. 1964(c) (Supp. I 1995), where the lawsuit alleges fraudulent conduct by a medical insurer.

1. Prior to this Court's decision in *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), it generally had been assumed that "[i]ssuing a policy of insurance [wa]s not a transaction of commerce," *Paul* v. *Virginia*, 75 U.S. (8 Wall.) 168, 183 (1869), and consequently that federal law did not apply to the business of insurance. *Department of Treas-*

ury v. *Fabe*, 508 U.S. 491, 499 (1993). In *South-Eastern Underwriters*, however, the Court held that an insurance company doing business across state lines was engaged in interstate commerce and was therefore subject to federal antitrust laws. Because that decision prompted concerns that federal law might be applied in a way that could damage "existing and future state systems for regulating and taxing the business of insurance," *Prudential Ins. Co.* v. *Benjamin*, 328 U.S. 408, 429 (1946), Congress in 1945 enacted the McCarran-Ferguson Act.

Among other things, the McCarran-Ferguson Act creates a special rule of statutory construction designed to prevent inadvertent federal preemption or impairment of state insurance law. In particular, Section 2(b) of the Act declares:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance * * * unless such Act specifically relates to the business of insurance.

15 U.S.C. 1012(b). As this Court has explained, Section 2(b) is designed to "remov[e] obstructions" to state insurance regulation "which might be thought to flow from [Congress's] own power, whether dormant or exercised, except as otherwise expressly provided in the Act itself or in future legislation." *Prudential*, 328 U.S. at 429-430.

2. Twenty-five years after passage of the McCarran-Ferguson Act, Congress enacted the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1961 *et seq.* See Organized Crime Control Act of 1970, Statement of Findings and Purpose, Pub. L. No. 91-452, 84 Stat. 923. In relevant part, RICO makes it unlawful for "any person employed by or

associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity." 18 U.S.C. 1962(c). Racketeering activity includes "any act 'indictable' under numerous specific federal criminal provisions, including mail and wire fraud." *Sedima, S.P.R.L.* v. *Imrex Co.*, 473 U.S. 479, 481 (1985); see 18 U.S.C. 1961(1).

The United States may bring criminal charges or initiate civil proceedings against RICO violators. See 18 U.S.C. 1963 (criminal penalties), 1964(a), (b) (civil proceedings by the Attorney General). In addition, RICO provides a private right of action under which "[a]ny person injured in his business or property by reason of a violation of" RICO may bring suit to recover "threefold" the damages sustained plus "the cost of the suit, including a reasonable attorney's fee." 18 U.S.C. 1964(c) (Supp. I 1995).

3. Respondents are certain beneficiaries of group health insurance policies issued by petitioner Humana Health Insurance of Nevada (Humana Insurance), and the employer-purchasers who paid the premiums for those policies. Pet. App. 2a. Under the health insurance policies, Humana Insurance was obligated to pay 80% of the beneficiary's hospital charges over and above a designated deductible amount; the beneficiary was to pay the remaining 20% as a co-payment. *Ibid.* Respondents allege that, beginning in 1985, petitioners engaged in a massive fraud to shift payment obligations from themselves to policy beneficiaries.

In particular, respondents charge that Humana Insurance and Humana Sunrise Hospital (Sunrise Hos-

pital) (an acute care facility in Nevada owned and operated by petitioner Humana, Inc.) entered into a secret arrangement under which Humana Insurance obtained discounts of between 40% and 96%. Pet. App. 2a-4a, 43a. According to respondents, the entire discount was credited toward Humana Insurance's 80% obligation. *Id.* at 3a-4a, 43a. Policy beneficiaries, in contrast, continued to be billed for their co-payments as though Sunrise Hospital were charging the full, undiscounted rate. *Id.* at 3a-4a. As a result, those making co-payments were misled into paying far more than 20%, and Humana Insurance paid far less than 80%, of total charges. *Id.* at 2a, 4a. For example, Humana Insurance might receive an 89% discount on a hospital bill of $5,000, and thus pay just $550 (11% of $5,000). The co-payor, however, would pay 20% of the undiscounted rate of $5,000, or a total of $1,000. See *id.* at 57a. Thus, of the $1,550 charged by Sunrise Hospital, $1,000 or nearly 65% would be paid by the policy beneficiary, while only $550 or just over 35% would be paid by Humana Insurance. Under respondents' understanding of the co-payment provision, co-payors should have paid just 20% of total charges, or $310, and Humana should have paid 80% of total charges, or $1,240. *Ibid.*

4. Respondents brought suit in the United States District Court for the District of Nevada, seeking recovery under several causes of action, including RICO. The policy beneficiaries, respondents asserted, had been economically injured by a pattern of racketeering activity in the form of mail, wire, radio, and television fraud, which had deceived them into making excessive co-payments. Pet. App. 20a-21a.[1]

[1] Respondents alleged that petitioners had concealed and misrepresented the secret agreement with Sunrise Hospital in numerous mailings, television and radio commercials, and telephone calls soliciting business, Pet. App. 21a; that petitioners concealed the discount arrangement by having Humana Insurance write checks to Sunrise Hospital for 80% of the undiscounted charges and having Sunrise Hospital remit the discount to Humana Insurance through monthly intercompany transfers, in what respondents characterized as a "classic kickback scheme," *id.* at 4a; and that such acts were intended to deceive and mislead co-payors into paying more than 20% of actual charges. To satisfy the "enterprise" element of RICO, respondents asserted that petitioners Humana, Inc., and Humana Insurance together constituted an "association in fact" enterprise conducted by each of the petitioners or, in the alternative, that Humana, Inc., a "person" within the meaning of 18 U.S.C. 1961(3), associated with Humana Insurance, an "association" within the meaning of 18 U.S.C. 1961(4). Pet. App. 21a.

Although respondents also asserted injury to the employer-purchasers of the policies, *id.* at 4a, those RICO claims are no longer part of this case.[2]

The district court granted petitioners' motion for summary judgment on the RICO claims, holding them precluded by the McCarran-Ferguson Act. Pet. App. 21a, 91a-96a. The McCarran-Ferguson Act, the district court ruled, precludes the application of a federal statute if (1) the statute does not "specifically relate[]" to the business of insurance, (2) the acts challenged under the statute constitute the business of insurance, (3) the State has enacted a law or laws regulating the business of insurance, and (4) the state law would be superseded, impaired, or invalidated by the application of the federal statute. *Id.* at 91a-92a. After concluding that the first three factors were

[2] The district court granted summary judgment for petitioners on those claims because of a lack of causation, Pet. App. 21a, 86a-87a, 89a-90a, and the court of appeals affirmed, *id.* at 26a-28a, 30a. Respondents have not sought review of those decisions.

satisfied, the court noted that Nevada has a comprehensive regulatory scheme addressing insurance trade practices and frauds. *Id.* at 93a-94a. Under that scheme, the Nevada Commissioner of Insurance has "exclusive jurisdiction in regulating the subject of trade practices in the business of insurance." Nev. Rev. Stat. § 686A.015 (1997) (quoted at Pet. App. 93a). Because RICO's private remedies, including its treble damages provision, far exceed the penalties prescribed by Nevada for the same conduct, the court concluded that application of federal law in this case would "invalidate, impair, or supersede" Nevada insurance law: "For this Court to allow [respondents] to pursue the harsher RICO penalties for behavior which the Nevada Legislature apparently did not deem worthy of such penalties, would be tantamount to allowing Congress to intercede in an area expressly left to the [S]tates under the McCarran-Ferguson Act." *Id.* at 95a.[3]

[3] The district court also granted summary judgment on several other claims. First, it granted summary judgment in favor of respondents on their claim under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 *et seq.* Pet. App. 10a, 54a-58a. The court, however, limited the amount of damages respondents could recover. *Id.* at 21a, 90a-91a (precluding the award of "damages in excess of the amount that they could have recovered under a proper interpretation of the co-payment provision."). Second, the court granted petitioners' motion for summary judgment on respondents' antitrust claims. *Id.* at 66a-80a. The grant of summary judgment in favor of respondents on the ERISA claims was not appealed; the grant of summary judgment on damages in favor of petitioners was affirmed on appeal, *id.* at 10a-11a; and the grant of summary judgment in favor of petitioners on the antitrust claims was reversed, *id.* at 11a-20a. None of those decisions, however, has been challenged in this Court.

5. The court of appeals reversed in relevant part, disagreeing with the district court's conclusion that the application of RICO would impair Nevada's regulatory scheme. Relying on its decision in *Merchants Home Delivery Service, Inc.* v. *Frank B. Hall & Co.*, 50 F.3d 1486, cert. denied, 516 U.S. 964 (1995), the court explained that the McCarran-Ferguson Act precludes the application of federal law in the area of insurance only if the federal law would conflict with state law. Pet. App. 25a. The mere existence of overlap in the coverage of Nevada insurance law and RICO, it held, "does not create a conflict between federal and state law" since neither law prohibits conduct that the other would permit. *Ibid.*

DISCUSSION

Because the federal appellate courts are divided on an important issue of statutory construction—the meaning of the phrase "invalidate, impair, or supersede" in the McCarran-Ferguson Act—a grant of certiorari to resolve the conflict would be appropriate. This case presents an adequate, although less-than-ideal, vehicle for so doing.

1. Section 2(b) of the McCarran-Ferguson Act provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance * * * unless such Act specifically relates to the business of insurance." 15 U.S.C. 1012(b). Because RICO does not "specifically relate[] to the business of insurance," federal courts repeatedly have been required to address whether permitting RICO actions alleging insurance fraud would "invalidate, impair, or supersede" state insurance law.

The Ninth Circuit has twice answered that question in the negative. In *Merchants Home Delivery*

Service, Inc. v. *Hall*, 50 F.3d 1486, cert. denied, 516 U.S. 964 (1995), the court held that permitting private parties to pursue a RICO action for insurance fraud would not invalidate, impair, or supersede California insurance law. Relying on the Seventh Circuit's decision in *NAACP* v. *American Family Mutual Ins. Co.*, 978 F.2d 287 (1992), cert. denied, 508 U.S. 907 (1993), the Ninth Circuit concluded that "state and federal laws proscribing identical conduct do not conflict with or displace each other, and may coexist under the McCarran-Ferguson Act," even if federal law offers greater remedies. 50 F.3d at 1492. And in this case, the Ninth Circuit reached the same conclusion. Pet. App. 25a.

The Sixth and Eighth Circuits have reached contrary results. In *Doe* v. *Norwest Bank Minnesota, N.A.*, 107 F.3d 1297, 1306-1308 (1997), the Eighth Circuit held that RICO's provision of remedies beyond those offered under state law would "frustrate, and perhaps even supplant, Minnesota's carefully developed scheme of [insurance] regulation." *Id.* at 1308. Likewise, in *Kenty* v. *Bank One, Columbus, N.A.*, 92 F.3d 384, 392-393 (1996), the Sixth Circuit concluded that the "different liability under [RICO and] Ohio law for violations, as well as different standards of proof * * * means that RICO does impair the ability of Ohio to regulate" deceptive or fraudulent insurance practices.

These divergent results cannot be entirely explained by reference to differences in the pertinent state insurance laws. In each of the cases, the insurance laws and the common law appear to prohibit the very conduct prohibited by RICO; the primary difference is that state law provides more limited remedies.[4] Consequently, the divergent results appear to be the product of differing—indeed, irreconcilable—interpretations of the McCarran-Ferguson Act and the terms "invalidate, impair, or supersede" in particular. As the Third Circuit recently noted: "Court of Appeals jurisprudence is in disarray as to the extent and meaning of invalidate, impair, or supersede under the Act." *Sabo* v. *Metropolitan Life Ins. Co.*, 137 F.3d 185, 193 (1998).

a. Under the reasoning of the First, Seventh, and Ninth Circuits, federal law generally does not "in-

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[4] This is not to say that there are no differences among the relevant state insurance laws. Those differences, however, do not appear to have influenced the results in these cases. For example, Nevada has recognized a private right of action under some of its insurance laws, while Minnesota and Ohio have not. Compare *Pioneer Chlor Alkali Co.* v. *National Union Fire Ins. Co.*, 863 F. Supp. 1237, 1241 (D. Nev. 1994), with *Morris* v. *American Family Mutual Ins. Co.*, 386 N.W.2d 233, 238 (Minn. 1986); *Everson* v. *Blue Cross and Blue Shield*, 898 F. Supp. 532, 544 (N.D. Ohio 1994). This distinction, however, cannot explain the division in authority because the Ninth Circuit in this case assumed that Nevada insurance law—like the insurance laws of Ohio and Minnesota—did not provide a private right of action. Pet. App. 25a. Moreover, the conflict between *Kenty* and *Doe* on the one hand and the Ninth Circuit's earlier decision in *Merchants Home* on the other cannot be reconciled based on differing availability of private enforcement mechanisms because the California insurance code provisions at issue in *Merchants Home*, like the laws of Ohio and Minnesota at issue in *Kenty* and *Doe*, "allow[ed] only administrative enforcement." *Merchants Home*, 50 F.3d at 1491. Finally, there is little reason why the availability of a private right of action under a State's insurance laws should be thought to make a difference, especially if the State continues to permit victims of insurance fraud to pursue common-law fraud actions outside of the administrative process in state court, as California, Minnesota, Nevada, and Ohio all do.

validate, impair, or supersede" state insurance law absent a direct conflict between the substantive provisions of the federal and state statutes at issue. See *Merchants Home*, 50 F.3d at 1492 (federal statutes "apply unless they conflict with the states' statutes"); *Villafane-Neriz* v. *FDIC*, 75 F.3d 727, 736 (1st Cir. 1996) ("[i]n the absence of a direct prohibition, we refuse to hold that there has been an impairment" of state insurance regulations); *American Family*, 978 F.2d at 295-297 ("state and federal rules that are substantively identical but differ in penalty do not conflict with or displace each other"); see *Sabo*, 137 F.3d at 193 ("One line of cases, spearheaded by the first, seventh and ninth circuit Courts of Appeals, looks to a direct conflict in the substantive provisions of the federal and state statutes at issue.").

These courts reason that the McCarran-Ferguson Act in effect creates a form of reverse preemption in order to avoid inadvertent federal interference with state insurance regulation. See *American Family*, 978 F.2d at 296 ("The McCarran-Ferguson Act is a form of inverse preemption."); *Merchants Home*, 50 F.3d at 1492 (same). Based on this analogy to Supremacy Clause preemption, the First, Seventh, and Ninth Circuits have concluded that "principles defining when state remedies conflict with (and so are preempted by) federal law are pertinent in deciding when federal rules 'invalidate, impair, or supersede' state rules." 978 F.2d at 296. Because the Supremacy Clause does not generally preclude States from providing additional remedies for conduct that is also prohibited by federal law,[5] these courts have concluded that federal statutes like RICO may provide additional remedies for conduct barred by state law without being displaced by the McCarran-Ferguson Act. As Judge Easterbrook observed in *American Family*, one who asserts that the McCarran-Ferguson Act precludes reliance on federal law "needs to show that the [federal law] conflicts with state law. Duplication is not conflict." 978 F.2d at 295.

[5] See, *e.g.*, *Silkwood* v. *Kerr-McGee Corp.*, 464 U.S. 238 (1984) (States may require payment of punitive damages by companies that violate a federal law governing the handling of radioactive waste, even if federal law would otherwise provide less compensation); *California* v. *ARC America Corp.*, 490 U.S. 93 (1989) (state antitrust law may require payment of treble damages to indirect purchasers even though federal antitrust law does not); *American Family*, 978 F.2d at 296 (citing additional cases).

The Ninth Circuit's decisions upholding the availability of RICO remedies in cases involving insurance fraud flow inevitably from this mode of analysis. Neither the California laws at issue in *Merchants Home* nor the Nevada statutes at issue in this case expressly permit—and both expressly prohibit—the sort of criminal insurance fraud necessary to support a RICO claim. Because RICO merely provides supplementary remedies for conduct that is also barred by state insurance law, the Ninth Circuit has concluded that RICO does not "invalidate, impair, or supersede" any California or Nevada law regulating insurance.

b. In contrast, under the analysis of the Eighth Circuit (and to some degree the Sixth Circuit, see note 8, *infra*), a difference in remedies may by itself preclude application of a general federal statute under the McCarran-Ferguson Act. *Doe*, *supra*; *Kenty*, *supra*. This may be true even where there is no conflict between the federal and state laws in their regulation of insurance practices. See, *e.g.*, *Doe*, 107

F.3d at 1307 (federal law inapplicable even though "there is no direct conflict between federal and state law").

In *Kenty* and *Doe*, the courts relied substantially on the facts that Minnesota and Ohio had decided to permit only the insurance commissioner, through administrative action, to enforce their respective insurance laws, and had not provided a treble damages remedy for victims of unlawful insurance practices. See *Doe*, 107 F.3d at 1307; *Kenty*, 92 F.3d at 392, 393. Although private parties remained free in those States to pursue common-law fraud actions in state court,[6] the Sixth and Eighth Circuits concluded that allowing parties to seek vastly greater remedies under RICO might upset the balance established by state insurance regulation—and thus impair it—by leading victims of fraud to pursue RICO actions rather than rely on state-law procedures. *Doe*, 107 F.3d at 1306-1307; *Kenty*, 92 F. 3d at 392.[7] The Sixth

[6] *Everson*, 898 F. Supp. at 544; *Wiltsey* v. *Fireman's Fund Ins. Co.*, No. C0-94-235, 1994 WL 306330 (Minn. Ct. App. Aug. 2, 1994) (unpublished opinion); see *Florenzano* v. *Olson*, 387 N.W.2d 168 (Minn. 1986).

[7] The treble damages and attorney's fees remedies available under RICO appear to have been critical in these decisions. In other cases, those same courts have concluded that reliance on federal statutes that provide additional remedies (such as a private right of action, jury trials, and punitive damages) but that lack a treble damages remedy is consistent with the McCarran-Ferguson Act. See, *e.g.*, *Nationwide Mut. Ins. Co.* v. *Cisneros*, 52 F.3d 1351 (6th Cir. 1995) (private party may proceed against insurer under Fair Housing Act even though the Act, unlike Ohio insurance law, provides a private remedy, permits jury trials, and allows for punitive damages), cert. denied, 516 U.S. 1140 (1996); *Doe*, 107 F.3d at 1307 (notwithstanding its holding that RICO claims are barred by McCarran-Ferguson, court might agree with the Sixth and

and Eighth Circuits therefore held that private actions under RICO are, in Minnesota and Ohio, precluded by the McCarran-Ferguson Act.[8]

c. The Third Circuit too has addressed this issue, but did not decide the extent to which "different federal and state remedies could ever" cause a federal statute to "impair" state insurance law. *Sabo*, 137 F.3d at 195. Like the First, Seventh, and Ninth Circuits, the Third Circuit agreed that a "direct conflict in the substantive provisions of RICO with those provided for [by state law] would fall within the ambit of laws that invalidate, impair, or supersede state

Seventh Circuit's decisions that the Fair Housing Act is consistent with McCarran-Ferguson).

[8] To some degree, the Sixth Circuit's opinion in *Kenty* may be read as supporting the actual-conflict standard articulated by the First, Seventh, and Ninth Circuits. For example, the *Kenty* opinion states that "[a] party seeking to invoke McCarran-Ferguson cannot simply point to additional procedural measures included in a federal law without identifying some substantive aspect of the state law that is being invalidated, impaired, or superseded." 92 F.3d at 392. Moreover, the court purported to identify such a substantive difference in *Kenty* itself: "Ohio law," the court noted, "may employ a different standard than * * * RICO to determine when a 'misrepresentation' violates its statute. * * * By holding insurance companies liable under a federal law, such as RICO, when Ohio law provides for no liability, RICO would impair the regulatory framework within which Ohio expects its insurance companies to do business." *Ibid.* In our view, that reasoning does not explain the result in *Kenty*, which appears instead to turn on RICO's treble damages provision. After all, Ohio law permits common-law fraud actions in insurance cases, see note 6, *supra*, under a standard of conduct that is no more permissive than the standard used in RICO mail-fraud actions. If Ohio common law bars the same misrepresentations that RICO does, it cannot be said that RICO provides for liability where Ohio law does not.

insurance law." *Id.* at 194. But it found no such contradiction in the case before it because Pennsylvania insurance law did not expressly permit or require any conduct that RICO would prohibit. *Ibid.*

In addition, the court found no evidence that a difference in the remedies offered under RICO and those available under state insurance law would indirectly impair state law, even assuming arguendo that such an indirect impairment could trigger application of the McCarran-Ferguson Act. Echoing this Court's analysis in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the court noted that RICO's purpose of allowing a liberal federal remedy to those who have been victimized by organized crime is not inconsistent with the purpose of Pennsylvania's insurance laws, which is to regulate trade practices by defining the practices that constitute unfair competition, unfair treatment of customers, or deception. Similarly, the court was not persuaded that allowing RICO actions would somehow undermine, "in a more abstract sense, Pennsylvania's overall implementation of insurance norms and its decision to enforce certain insurance violations in an administrative context." 137 F.3d at 195. To the contrary, because "[p]rivate actions for fraud and deceit in the insurance business coexist with [state insurance law] even though the same conduct may be covered by both the common law and [state insurance law]," the court saw "no reason why a federal private right of action cannot [also] coexist with" state insurance law. *Ibid.*[9]

[9] As petitioners also point out, the Fourth Circuit in an unpublished decision has upheld a district court order holding that the McCarran-Ferguson Act bars reliance on civil RICO in the insurance context in Virginia. *Ambrose* v. *Blue Cross & Blue Shield*, 891 F.Supp. 1153, 1164-1168 (E.D. Va. 1995), aff'd, 95 F.3d 41 (1996) (Table). It is unclear whether that unpublished decision represents the law of the Fourth Circuit, as the Fourth Circuit's published decision in *Mackey* v. *Nationwide Insurance Cos.*, 724 F.2d 419 (1984), suggests that the Fourth Circuit might align itself not with the Sixth and Eighth Circuits but rather with the First, Seventh, and Ninth. See 724 F.2d at 421 & nn. 1-2 (declining to find impairment absent a direct conflict between state insurance law and federal Fair Housing Act requirements).

2. In our view, the Eighth and Sixth Circuits' analyses are flawed. As Judge Easterbrook explained in *American Family*, anyone asserting that the McCarran-Ferguson Act precludes the application of federal law must identify the "state law regulating the business of insurance" that the federal law would "invalidate, impair, or supersede." 978 F.2d at 295; see *Mackey* v. *Nationwide Ins. Cos.*, 724 F.2d 419, 421 (4th Cir. 1984) (individual relying on McCarran-Ferguson must "point[] to [a] law enacted by [the State] which would be 'impaired' by application" of federal law). "The presence of a general regulatory scheme" addressing insurance, like the regulatory regimes identified in *Doe* and *Kenty*, "does not show that any particular state law would be invalidated, impaired, or superseded." *Mackey*, 724 F.2d at 421. To the contrary, if federal law and state law both prohibit the same conduct, RICO's additional remedies at most enhance the vindication of state norms. Nor can it be said that RICO's additional remedies supplant reliance on state remedial schemes, as RICO reaches only a small subset of state insurance-law infractions. Its greater remedies may be invoked only in exceptional cases where the elements of a RICO violation can be proved—cases in which the defendant has not merely committed a tort or regulatory violation, but

instead has demonstrated extreme culpability by operating an "enterprise" through a "pattern" of indictable criminal activity. 18 U.S.C. 1962(c).[10]

The ordinary, and eminently sensible, presumption is that a federal law of general applicability, such as RICO, applies uniformly to all persons whose conduct falls within the statutory proscription. Under our system of equal justice under law, this is true regardless of the particular factual context or the particular State in which the conduct occurs, so long as Congress does not exceed its constitutional powers. The rule of statutory construction prescribed by the McCarran-Ferguson Act should not be distorted to create disuniformities in the application of other Acts of Congress in the absence of a showing that the particular disuniformity is indeed required to prevent a state law "regulating the business of insurance" from actually being "invalidate[d], impair[ed], or supersede[d]." No such showing has been made here.

3. This case raises issues of substantial importance to the United States. Although we are not

[10] Even if one were to assume that RICO, by "increasing the probability that a state norm will be vindicated (or augmenting the damages assessed in the event of violation)," might be said to conflict with a state policy "that remedies should be limited or rare," *American Family*, 978 F.2d at 295, few if any States have articulated such a low- or no-enforcement policy with appropriate clarity. To the contrary, States almost uniformly permit common-law fraud actions—which can result in jury trials and punitive damages awards—to co-exist with their insurance regulations. If such "[p]rivate actions for fraud and deceit in the insurance business coexist with" state insurance laws even though "the same conduct may be covered by both," there is "no reason why a federal private right of action" under RICO cannot "coexist" with state insurance law as well. *Sabo*, 137 F.3d at 195.

aware of any instance in which the United States has brought a civil RICO action in the insurance area, the United States routinely prosecutes criminal activity in the business of insurance under RICO and other federal criminal statutes, and has in the past obtained civil injunctions under 18 U.S.C. 1345 to bar the operation of insurance-related entities engaged in fraud. See, *e.g.*, *United States* v. *Employee Ins. Servs.*, Civ. No. 1-93-CV-181 (N.D. Ga., Complaint filed Jan. 27, 1989) (civil action brought with cooperation of state regulators to enjoin fraudulent activity involving collection of premiums).[11]

The United States thus has a strong interest in ensuring that the McCarran-Ferguson Act is not interpreted in a manner that would interfere with its ability to enforce RICO and other federal statutes against criminals operating in the insurance arena where federal law does not conflict with the norms established by state insurance law. The questions whether the government may bring a civil or criminal action consistent with the McCarran-Ferguson Act, and whether a private party may bring a suit for

[11] Although the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS) may in some instances encounter insurance fraud issues in its administration and enforcement of the Medicare Act, 42 U.S.C. 1395 *et seq.*, that Act provides its own remedies for fraudulent billing by medical providers. See, *e.g.*, 42 U.S.C. 1320a-7, 1320a-7a, 1320c-5, 1395*l*, 1395m, 1395u, 1395dd, 1396b. (Additional remedies for fraud can be found under 31 U.S.C. 3729 *et seq.*, and 31 U.S.C. 3801 *et seq.*) The Inspector General of HHS also investigates fraud in the Medicare program but likewise has relied on Medicare Act remedies. Reliance on those remedies, because they specifically relate to the business of insurance, obviously is not precluded by the McCarran-Ferguson Act.

treble damages, however, are informed by different considerations.[12] As a result, courts have held that the United States can proceed under RICO consistent with the McCarran-Ferguson Act even if a private party cannot.[13] Nonetheless, because of the

[12] As the Seventh Circuit recently explained: "[T]here are fundamental differences between a private individual as a plaintiff and the government as a civil litigant in RICO claims. * * * The government seeks to vindicate public harm and to protect the public from systematic and pervasive criminal activities while the individual seeks to enforce private rights in a civil RICO cause of action. Therefore, a test used by courts to determine whether a civil RICO claim [is barred by the operation of another federal statute] does not translate into a valid indicator that [the same federal statute] would also [preclude] the prosecution of a criminal RICO offense." *United States* v. *Palumbo Bros.*, No. 97-3807, 1998 WL 224892, at *19 (May 7, 1998). Moreover, while state law often may give private parties other means to vindicate their interests, it often does not afford the national government a means for vindicating the public's interest in law enforcement. It is highly unlikely that Congress intended "that the government not have the ability to protect the general public from crime and to vindicate public harm for racketeering activities," *ibid.*, simply because the racketeering happens to arise in the insurance context.

[13] See *United States* v. *Blumeyer*, 114 F.3d 758, 768 (8th Cir.) (although private action is barred by McCarran-Ferguson Act, criminal RICO prosecution is not barred because fear that "wronged policyholders would turn to RICO suits instead of pursuing administrative channels of relief * * * is simply inapplicable" to criminal actions), cert. denied, 118 S. Ct. 350 (1997); see also *United States* v. *Cavin*, 39 F.3d 1299, 1305 (5th Cir. 1994) (because State's regulatory interests and federal interest in prosecuting fraud are "completely compatible," the McCarran-Ferguson Act does not bar prosecution under federal law); *United States* v. *Sylvanus*, 192 F.2d 96, 100 (7th Cir. 1951) (criminal mail fraud prosecution based on insurance

potential effect on federal law enforcement, cf., *e.g.*, *United States* v. *Palumbo Bros.*, No. 96 CR 613 (N.D. Ill. Oct 9, 1997) (order dismissing indictment), rev'd, No. 97-3807, 1998 WL 224892, at *19 (7th Cir., May 7, 1998), and because the ability of individuals to pursue federal remedies for criminal conduct may depend not on the substance of state insurance law or federal statutory requirements, but rather on the circuit in which their case happens to arise, the question presented in this case warrants the Court's plenary attention.

4. There is nonetheless one respect in which this case is not an ideal vehicle for consideration of this question. As noted above, the Ninth Circuit's conclusion that Nevada insurance law "provides for only administrative remedies," Pet. App. 25a, may be partially incorrect. See note 4, *supra*. In fact, Nevada permits private litigants to seek judicial redress through private actions brought directly under some provisions of its insurance laws. See *Pioneer Chlor Alkali Co.* v. *National Union Fire Ins. Co.*, 863 F. Supp. 1237, 1243 (D. Nev. 1994) ("NRS 686A.310 expressly provid[es] insureds with a private cause of action.").[14] To the extent the results in *Doe* and *Kenty* are predicated on the absence of a private right of action under Minnesota's and Ohio's insurance laws, it is possible that RICO actions in Nevada thus could be held permissible even under the Sixth

scheme to defraud not inconsistent with insurance regulation), cert. denied, 342 U.S. 943 (1952).

[14] Nev. Rev. Stat. § 686A.310.2 (1997) might arguably authorize a private action if petitioners, through the alleged conduct, see pp. 4-5 & n.1, *supra*, "misrepresent[ed] to insureds * * * pertinent facts or policy provisions relating to any coverage at issue," in violation of Nev. Rev. Stat. § 686A.310.1(a).

and Eighth Circuit's approach—although the rationale would be quite different from that adopted by the Ninth Circuit in this case. See *Doe*, 107 F.3d at 1307 (RICO action impairs state regime because the "[S]tate of Minnesota has determined that its insurance market can best be regulated by the Commissioner's pursuit of fines and injunctive relief").

This does not, however, make the conflict in the circuits less than genuine: The Ninth Circuit in *Merchants Home*, *supra*, held that RICO actions are consistent with the McCarran-Ferguson Act in California notwithstanding the absence of a private right of action under California's insurance laws. See note 4, *supra*. Moreover, in our view, the results in *Kenty* and *Doe* appear to have turned on RICO's provision of treble damages rather than the fact that RICO (unlike state insurance law) makes a judicial forum available. See note 7, *supra*. Indeed, it is difficult to see why a State's failure to create a private right of action under its insurance laws should be thought to make a difference, especially where the State permits private litigants to obtain a judicial rather than administrative forum by bringing a common-law fraud action in state court. Nonetheless, the possibility that the result in this case could be the same under any circuit's approach is a consideration that weighs against granting certiorari. On balance, however, we believe that the conflict in the circuits is adequately presented here and warrants resolution by this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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MAY 1998

No. 97-303

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

Humana Inc. and
Humana Health Insurance of Nevada, Inc.,
Petitioners,

v.

Mary Forsyth, Marietta Cade,
Willie Andrews, Mary Lou Buehler,
Helen Staves, Randolph Bratton,
and Searle Auto Glass, Inc.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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PETITION FOR CERTIORARI FILED AUGUST 18, 1997
CERTIORARI GRANTED JUNE 22, 1998

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UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH, ROBERT AND MARRIETTA CADE, WILLIE ANDREWS, MARY LOU BUEHLER, HELEN STAVES, RANDOLPH BRATTON, SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY, W. E. KRUMMEL, SR.,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation, GROUP HEALTH INSURANCE, INC., a Delaware corporation, HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation, and DOE CORPORATIONS I through V, inclusive,

Defendants.

COMPLAINT AND JURY DEMAND

COME NOW, Plaintiffs Mary Forsyth, Robert and Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, Searle Auto Glass, Inc., d/b/a Best Glass Co., and W. E. Krummel, Sr., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, and Waite, Schneider, Bayless & Chesley Co., L.P.A., and for their causes of action against Defendants complain, aver and allege as follows:

JURISDICTION

1. This action arises under the laws of the United States and includes claims under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, the antitrust laws of the United States, 15 U.S.C. § 1 *et seq.*, and the law of the State of Nevada. Subject matter jurisdiction in conferred upon this Court by 29 U.S.C. § 1132, 15 U.S.C. § 15, 28 U.S.C. §1237, and the doctrine of ancillary and pendent jurisdiction.

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 28 U.S.C. § 1391 and 29 U.S.C. § 1132.

BACKGROUND

3. Plaintiffs are individuals and entities utilizing health care services and/or the health insurance plan of Defendant, Humana, Inc. ("Humana"), and its wholly owned subsidiary Defendant, Humana Health Insurance of Nevada, Inc. ("Humana-Insurance"). Humana owns and operates Humana Hospital-Sunrise, an acute care facility located in Clark County, Nevada. Group Health Insurance, Inc. ("Group-Insurance") is a wholly owned subsidiary of Humana and it retains beneficial interest in 100% of the stock of Humana-Insurance. Plaintiffs and the class are suing the Defendants for the damages they sustained as a result of

the methods by which Defendants operated the health insurance plan and Humana Hospital-Sunrise. The Defendants, through a scheme of self-dealing, funneled monies from Humana Hospital-Sunrise to Humana-Insurance in order to hide excess profits being made by the hospital. Plaintiffs are demanding damages as well as declaratory relief and the imposition of a constructive trust as a result of the Defendants' wrongful conduct.

PARTIES

4. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. At Kreel Printing health insurance was optional. Some employees, like Ms. Forsyth, took insurance and some did not. In September 1986 Ms. Forsyth was hospitalized at Humana Hospital-Sunrise. In nine days of hospitalization she incurred a bill of $21,971.76. As a result of her co-payment provisions, Ms. Forsyth paid $2,300.00 out of her own pocket for that hospitalization.

5. Plaintiffs Robert and Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada have been insured with Humana-Insurance since 1985. Both Robert and Marrietta Cade worked for many years at the Las Vegas Sun. Mr. Cade terminated his employment with the Las Vegas Sun in late 1985 and Mrs. Cade terminated her employment in December 1988. Mr. Cade was hospitalized at Humana Hospital-Sunrise between October 7, 1987 and October 17, 1987. Mr. Cade incurred a hospital bill of $16,437.66. The Cades paid all appropriate co-payments for his hospitalization. The Cades were at all times relevant Humana-Insurance insureds and currently remain personally insured with Humana Care Plus paying a monthly premium of $355.00 per month.

6. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. Mr. Andrews was hospitalized from November 4, 1986 through November 9, 1986. At all times relevant Mr. Andrews was employed with the Clark County School District. Mr. Andrews, under his co-pay provisions, was obligated to pay a percentage of all of his hospitalization costs as well as the premium payments paid by him through his employer.

7. Plaintiff Mary Lou Buehler, 210 Meyers Avenue, Henderson, Nevada 89015, has been insured with Humana-Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband an optional premium is paid of approximately $140.00 per month for her coverage as a dependent. In September 1987 and again in October of 1988 Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her billings for those hospitalizations were $23,293.94 and $2,736.85, respectively. Under the co-payment provision of her policy, she was obligated to pay 20% of the costs of her hospitalization, over and above the premium payments.

8. Plaintiff Helen Staves, 37 East Stewart, Unit 50, Las Vegas, Nevada 89110, has been insured with Humana-Insurance since July 1988. In December 1988 Ms. Staves was hospitalized at Humana Hospital-Sunrise. Pursuant to the co-payment provisions under her policy, she is required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.25. At all times relevant, Mrs. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana-Insurance.

9. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with

Humana-Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987, Mr. Bratton has been employed by the Clark County School District. Mr. Bratton remains in the employ of Clark County School District to this date. At all times relevant, Mr. Bratton was an insured of Humana-Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital-Sunrise. At that time, day surgery was performed and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated on that amount as Humana-Insurance has denied the claim of payment as a pre-existing condition.

10. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. ("Best Glass"), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has utilized Humana-Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass group number with Humana-Insurance is 82801-18351-001. When Best Glass first became an insured with Humana-Insurance, the rates were very reasonable, $64.23 per employee per billing period. In 1986 this rate increased by 3% and in 1987 the rate jumped 13%. Finally, when Best Glass decided not to renew with Humana-Insurance, it sought a premium increase of 41% to continue coverage of employees of Best Glass. At no time did Humana-Insurance ever inform Best Glass that it was able to negotiate favorable hospitalization rates for its employees using Humana Hospital-Sunrise for hospitalizations.

11. Plaintiff W. E. Krummel, Sr., 1225 S. Commerce Street, Las Vegas, Nevada 89102, was an insured with Humana-Insurance and an employee of Best Glass between 1985 and 1988, inclusive.

12. The named Plaintiffs are: employers who have provided insurance to their employees through Humana-Insurance, insureds of Humana-Insurance, claimants under the health insurance policies issued by Humana-Insurance (''Humana Care Plus''), and individuals who have utilized the health care services of Humana.

13. Defendant Humana-Insurance is a Nevada corporation in good standing conducting business in the County of Clark, State of Nevada and is a wholly owned subsidiary of Humana (through Group-Health).

14. ''Group-Insurance'' is a Delaware corporation holding beneficial interest in all of the stock of Humana-Insurance and is itself a wholly owned subsidiary of Humana.

15. Defendant Humana is a Kentucky corporation licensed to do business in the State of Nevada.

16. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOE CORPORATIONS I through V, inclusive, are unknown to Plaintiffs at this time, who therefore sue said Defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each of said Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will seek leave to amend this Complaint to allege their true names and capacities when and as ascertained.

CLASS ACTION ALLEGATIONS

17. This section is brought by Plaintiffs as a class action on their own behalf and on behalf of the following classes and all others similarly situated, under the provisions of Rule 23(a) and Rule 23(b)(1)(B), (2) and (3) of the Federal Rules of Civil Procedure, for damages, equitable relief and declaratory relief, including costs and attorneys' fees.

(a) A class consisting of employers and individuals contracting with Humana-Insurance and paying premiums on behalf of themselves and/or their employees; and

(b) A class consisting of individuals who were hospitalized at Humana Hospital-Sunrise and who were insured with Humana-Insurance.

18. The classes are represented by Plaintiffs in this action of which Plaintiffs are themselves members, and consist of all those insured by Humana-Insurance and/or or who received inpatient hospitalization at Humana Hospital-Sunrise and/or who made premium payments to Humana-Insurance at all times relevant hereto.

19. The members of the class of Plaintiffs are so numerous that joinder is impractical. The exact number of the members of the class is unknown to Plaintiffs, but may be determined from records maintained by Defendants Humana and Humana-Insurance. It is estimated that there may be tens of thousands of plaintiffs. In many instances the members of the class are unaware that claims exist or are about to be brought, or are unaware of the facts giving rise to such claims, or having knowledge of such claims, or having knowledge of such claims, had, in many instances, sustained damages in such an amount that when taken individually are too small to justify the enormous expense and effort required to sue separately. Nevertheless, the damages and class members as a group are substantial and significant to justify the taking of legal action.

20. There are common questions of law and fact in the action that relate to and affect the rights of each member of the class and the relief sought in common to the entire class. Each Plaintiff asserts that Humana and Humana-Insurance in 1985, 1986, 1987 and 1988 operated a scheme to unlawfully

and/or inequitably profit from hospitalizations at Humana Hospital-Sunrise.

21. This action is properly maintained as a class action inasmuch as the questions of law and fact common to all members of the class predominate over any questions affecting only individual members, and the class action is superior to other available methods for the fair and efficient adjudication of this controversy. Among the questions of law or fact common to the classes are the following:

(a) Whether Defendants breached their contractual obligations to Plaintiffs to provide hospital services at a reasonable price?

(b) Whether Humana-Insurance breached its obligation to its Plaintiff insureds to pass along reduced costs in the form of reduced premiums?

(c) Whether Defendants participated in a scheme to unlawfully and/or inequitably funnel monies from Humana to Humana-Insurance in 1987 and 1988 in violation of state law and in breach of their obligations to plaintiffs?

(d) Whether Defendants unlawfully and/or inequitably failed to reduce co-payments and deductible payments of plaintiffs for hospitalizations at Humana-Sunrise?

(e) Whether Defendants by their conduct violated federal and state antitrust laws?

(f) Whether Defendants have been unjustly enriched by the scheme described herein?

(g) Whether Plaintiffs and the class have been damaged and the extent of those damages?

22. The claims of Plaintiffs, who are represented as of the class herein, are typical of the claims of the class, in that the

claims of all members of the class, including Plaintiffs, depend upon a showing of the acts and omissions of Defendants giving rise to the right of Plaintiffs to the relief sought herein.

23. The named Plaintiffs are the representative parties for the class, and are able to, and will, fairly and adequately protect the interest of the class. The attorneys for Plaintiffs are experienced and knowledgeable in the field and have successfully represented claimants in other litigation.

24. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(1)(B) because prosecution of separate actions by individual members of the class would create a risk of adjudications with respect to individual members of the class that would, as a practical matter, dispose of the interest of the other members not parties to the adjudications, or which substantially impair or impede their ability to protect their interests.

25. This action is properly maintained as a class action under FRCP 23(b)(2) inasmuch as the Defendants, all of whom oppose the class, have acted or refused to act, as herein more specifically allege, on grounds which are applicable to the class and have by reason of such conduct, made appropriate final equitable relief and declaratory relief with respect to the entire class, as sought in this action.

FIRST CLAIM FOR RELIEF

(Breach of ERISA Fiduciary Duties)

26. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

27. Many of the members of the class are employers or employees obtaining or providing health insurance benefits under an employee benefit plan as defined under 29 U.S.C. 1001, *et seq*.

28. Defendant Humana-Insurance is the insurer of a class of Plaintiffs through its insurance plan, Humana Care Plus. Under the Humana Care Plus policy, Humana-Insurance has fiduciary duties to Plaintiffs who fall under ERISA protection. 29 U.S.C. §§ 1104 and 1105.

29. Under 29 U.S.C. 1001, *et seq.*, Humana and Humana-Insurance, as fiduciaries of Plaintiffs, have a duty to provide health insurance at a reasonable cost.

30. Humana and Humana-Insurance entered into an agreement to reduce hospitalization costs for Humana-Insurance plaintiffs.

31. Defendant Humana-Insurance has breached its fiduciary duties to all Plaintiffs protected by ERISA in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced premiums and co-payments.

32. Plaintiffs have been damaged as a result of the breach of its fiduciary duties by Humana and Humana-Insurance.

33. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

SECOND CLAIM FOR RELIEF

(Constructive Trust)

34. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

35. The Defendants have retained profits in excess of $10,000,000.00 as a result of the scheme described herein.

36. Such monies were unlawfully obtained in contravention of Assembly Bill 289, as passed by the 1987 Nevada Legislature and signed into law by the Governor of the State of Nevada ("AB 289"), and further are in violation of the Defendants' duties to the Plaintiffs. 29 U.S.C. 1001, *et seq.*

37. It would be wrongful for Humana and Humana-Insurance to retain monies, in excess of those they might otherwise have been entitled to, when such monies have been obtained through the breach of federal and state law and Humana-Insurance agreement with Plaintiffs.

38. A constructive trust should be imposed on the Defendants which requires turnover of all monies obtained through the scheme described herein.

39. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

40. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

THIRD CLAIM FOR BELIEF

(Breach of Contract)

41. Plaintiffs reassert and reallege each and every allegation contained in Paragraphs 1 through 25 of the General Allegations.

42. Defendant Humana-Insurance is the insurer of a class of Plaintiffs through its insurance plan, Humana Care Plus. Under the Humana Care Plus policy and the laws of the State of Nevada, Humana-Insurance is obligated to pass along reduced costs to its insureds in the form of reduced premiums.

43. Humana and Humana-Insurance entered into an agreement to reduce hospitalization costs for Humana-Insurance plaintiffs.

44. Defendant Humana-Insurance has breached its obligation to Plaintiffs under the Humana Care Plus policy in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced premiums.

45. Defendant Humana-Insurance has breached its agreement with Plaintiffs causing damages in the form of increased premiums and excessive co-payments paid during hospitalization stays at Humana Hospital-Sunrise.

46. As a result of defendants breach Plaintiffs have suffered damages in excess of $10,000,000.00.

47. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

FOURTH CLAIM FOR RELIEF

(Unfair Claims Practices)

48. Plaintiffs reassert and reallege each and every allegation contained in Paragraphs 1 through 46 of the Complaint as though fully set forth at this point.

49. Humana-Insurance is engaged in the business of insurance in the State of Nevada and policies of insurance were issued and delivered to Plaintiffs and the members of the class were employees or insureds within the State of Nevada.

50. Humana-Insurance committed the following acts in violation of the Nevada Unfair Claims Practices Act, 686A.310 in that it:

(a) Failed to pass along premium reductions to their insureds;

(b) Failed to properly process claims of its insureds;

(c) Failed to notify insureds that they had overpaid their co-payments and deductibles; and

(d) Failed to make prompt and reasonable settlements of all claims presented.

51. The above acts constitute violations of HRS 686A.310 and there is a private right of action for all such acts committed in 1987 and 1988.

52. Plaintiffs and the members of the class have suffered damages in an amount in excess of $10,000,000.00.

53. It has been necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

FIFTH CLAIM FOR RELIEF

(Breach of the Implied Covenant of Good Faith and Fair Dealings)

54. Plaintiffs reassert and reallege each and every allegation contained in Paragraphs 1 through 52 of the Complaint as though fully set forth at this point.

55. Implied in the Humana-Insurance health insurance policies with Plaintiffs is the covenant of good faith and fair dealings governing its conduct with Plaintiffs.

56. Humana-Insurance has breached the covenant of good faith and fair dealings in that it has failed to properly handle the claims of Plaintiffs and notify Plaintiffs of reduced premiums and cost savings that were agreed to by its parent corporation, Humana.

57. Humana-Insurance's conduct as described herein is willful, wanton, malicious and/or is in conscious reckless disregard for the rights or Plaintiffs, its insureds.

58. As the proximate result of the conduct of Humana-Insurance, Plaintiffs have been damaged generally and specially in an amount in excess of $10,000,000.00 and are entitled to punitive damages.

59. It has been necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

SIXTH CLAIM FOR RELIEF

(Anti Trust)

60. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

61. Defendants Humana and Humana-Insurance provided services within the State of Nevada, County of Clark, to Plaintiffs. Defendants are also engaged in the business of interstate commerce. Defendants offer their services both to in-state and out-of-state patients and/or insureds.

62. Humana-Insurance, although a wholly owned subsidiary of Group-Health, which in turn is wholly owned by Humana, was at all times relevant hereto treated as an independent and separate entity by Humana, and entered into an arm's length agreement with Humana. Humana and Humana-Insurance conspired to operate a scheme which includes the following components:

(a) Initially offering extremely low premium rates for the Humana Care Plus policy with the intention of dramatically increasing those rates once market penetration was obtained;

(b) Requiring extensive penalities for Plaintiffs who failed to utilize the services of the only "preferred provider hospital" in the Southern Nevada area, Humana Hospital-Sunrise;

(c) Creating a boycott of all other acute care providers (by effectively forcing all Humana-Insurance insureds to be treated at Humana Hospital-Sunrise) in the Southern Nevada area for insureds of Humana-Insurance.

63. Defendants, by operating the scheme described herein, have implemented a system designed in the long-term to reduce or eliminate price competition within the greater Las Vegas metropolitan area.

64. Defendants' scheme of predatory pricing and boycotting along with the other activities described herein constitutes a conspiracy which is intended to and does in fact unreasonably restrain trade and commerce in the relevant geographic market in violation of 15 U.S.C. §§ 1 and 2 and HRS 598A.910, *et seq.*, all to the damage and detriment of Plaintiffs.

65. Plaintiffs are entitled to receive costs of suit and reasonable attorneys' fees and Plaintiffs' damages are to be trebled for the conduct described herein. 15 U.S.C. § 15.

SEVENTH CLAIM FOR RELIEF

(Unjust Enrichment)

66. Plaintiffs reassert and reallege each and every allegation contained in paragraph 1 through 64 of the Complaint as though fully set forth at this point.

67. As a result of the Defendants' unlawful, and/or inequitable scheme heretofore alleged, Plaintiffs conferred a monetary benefit upon the Defendants. Defendants appreciated and realized the monetary benefit and Defendants accepted and retained the monetary benefit under circum-

stances such that it would be inequitable for the Defendants to retain the monetary benefit without returning the benefit to Plaintiffs. As a result of the scheme, the Defendants were unjustly enriched.

68. As a direct and proximate result of the unjust enrichment, Plaintiffs have suffered damages in an amount in excess of $10,000,000.00.

69. It has been necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

EIGHTH CLAIM FOR RELIEF

(Declaratory Relief)

70. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

71. A declaratory judgment pursuant to Rule 57 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, as well as NRCP 57, therefore, is needed to judicially declare the rights of Plaintiffs and all class members under the Humana-Insurance policy, to prevent further abuses that threaten Plaintiffs and all class members' ability to obtain medical insurance at reasonable premiums and to pay reasonable co-payments, where applicable.

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $10,000,000.00 on the First Claim for Relief.

2. A constructive trust to be imposed upon the Defendants in the amount of all monies received as a result of the

scheme, with Plaintiffs to be named as the beneficiaries of the trust on the Second Claim for Relief.

3. An amount in excess of $10,000,000.00 on the Third Claim for Relief.

4. For general, special, compensatory and punitive damages in the amount in excess of $10,000,000.00 on the Fourth Claim for Relief.

5. For general, special, compensatory and punitive damages in the amount in excess of $10,000,000.00 on the Fifth Claim for Relief.

6. For general, special, compensatory and punitive damages in the amount in excess of $10,000,000.00 on the Sixth Claim for Relief.

7. An amount in excess of $10,000,000.00 on the Seventh Claim for Relief.

9. For judgment by this court establishing the rights and duties between the parties and for judgment requiring Defendant to cease and desist from the wrongful conduct described in the Complaint on the Eighth Claim for Relief.

10. For costs of suit and fees incurred herein.

11. For such further and other relief as the Court deems just and equitable.

DATED this 29th day of March, 1989.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

/s/ Stanley M. Chesley
STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS & CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth & Vine Streets
Cincinnati, Ohio 45202

ATTORNEYS FOR PLAINTIFFS

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

/s/ Stanley M. Chesley
STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS & CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth & Vine Streets
Cincinnati, Ohio 45202

ATTORNEYS FOR PLAINTIFFS

[Letterhead of LIONEL SAWYER & COLLINS]
[Las Vegas, Nevada]

TELECOPY TRANSMITTAL FORM

DATE: 4-18-89
TO: Tom Brock
FIRM: Casson, Harkins & LaPallo FAX # (202) 338-1479
FROM: Dennis Kennedy TIME 11:12 A.M. FILE # 3814-105
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CONFIRMATION #: (202) 778-1100

CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of June, 1987, I caused a copy of the foregoing to be served via first class mail, postage prepaid, to:

Gary D. Greenwald, Trial Attorney
Schottenstein, Zox and Dunn
41 S. High Street
Columbus, Ohio 43215

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tyw:004-72Cons

NEVADA
COMPREHENSIVE
CONTRACT
REVISED
9/26/84

3201 South Maryland Parkway
Las Vegas, Nevada 89109

HUMANA CARE PLUS
HUMANA HEALTH INSURANCE COMPANY
OF NEVADA, INC.

This policy contains the terms under which the Insurance Company agrees to insure certain Employees and pay benefits.

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

THIS POLICY CONTAINS A DEDUCTIBLE

Secretary
/s/ Alise F. Newton

President
/s/ Henry J. Wenonen

[HCP-84-NV-1]

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[Section 2 2-1]

POLICYHOLDER: SAHARA & HACIENDA HOTELS

ADDRESS: P.O. BOX 18437
LAS VEGAS, NEVADA 89114

POLICY NUMBER: 78274

EFFECTIVE DATE: FEBRUARY 1, 1985

ANNIVERSARY DATE: FEBRUARY 1

HUMANA CARE PLUS
GROUP COMPREHENSIVE MEDICAL EXPENSE INSURANCE POLICY

[HCP-84-NV-1]

INDIVIDUAL MAXIMUM LIFETIME BENEFIT	$1,000,000
CALENDAR YEAR DEDUCTIBLE EACH PERSON	$200
CALENDAR YEAR DEDUCTIBLE EACH FAMILY	$400
HOSPITAL BENEFIT	
—Participating Hospital Room and Board and Other Services	90% of Semi-Private

—Non-Participating Hospital Room and Board and Other Services	70% of Semi-Private
Deductible Each Admission	$1,200
BENEFIT PERCENTAGE FOR OTHER MEDICAL SERVICES (Except Where Provided Otherwise)	80%
PERSONAL EXPENSE LIMIT BY EACH INSURED FOR COVERED CHARGES IN A CALENDAR YEAR*	$1,000
PERSONAL EXPENSE LIMIT BY EACH FAMILY FOR COVERED CHARGES IN A CALENDAR YEAR*	$2,000
MENTAL AND NERVOUS DISORDER BENEFIT	
In-Patient — Hospital Maximum Calendar Year	30 days
Out-Patient — Maximum Covered Expense Calendar Year	$1,000
ALCOHOLISM AND DRUG ABUSE COURSE OF TREATMENT	
Detoxification — Maximum Days Calendar Year	7
In-Patient Maximum Covered Expense Calendar Year	$10,000
Out-Patient — Maximum Covered Expense Calendar Year	$1,500
Lifetime Maximum Courses of Treatment	3
SPECIALTY CARE FACILITY BENEFIT	
Calendar Year Maximum	60 days

HOME HEALTH CARE SERVICES

Maximum Visits Calendar Year 40

PRE-EXISTING CONDITION BENEFIT MAXIMUM

Maximum Expense $2,000

SUPPLEMENTAL ACCIDENT BENEFIT $500

*Does Not Include Deductibles

[Section 3 (NV-Rev. 8-84) 3-1]

Deductible for any person or family will be reduced to the extent that the Comprehensive Medical Deductible for the prior calendar year was deducted from Covered Expenses incurred for that person during October, November, and December of such year.

[Section 3 3-2]

ACTIVE SERVICE. An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if he is performing in the usual way all of the regular duties of his work for the Employer on a full-time basis on that day, either at one of the Employer's places of business or at some location to which the Employer's business requires him to travel. An Employee will be deemed in Active Service on a day which is not one of the Employer's scheduled work days only if he was in Active Service on the preceding schedule work days.

COVERED CHARGES OR COVERED EXPENSES. The terms mean charges or expenses incurred for medical care to the extent they are covered by this policy and for which benefits are payable.

EMPLOYEE. The term Employee means a full-time employee of the Employer, but does not include employees

who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

EMPLOYER. The term Employer means the Policyholder and all Affiliated Employers shown in the "Eligibility for Insurance" section.

[Section 4 (NV-Rev. 8-34) 4-1]

DEPENDENT. The term Dependent means:

(1) the lawful spouse of the Employee; and

(2) any unmarried child who is

(a) less than 19 years old;

(b) 19 years but less than 25 years old, enrolled in a school as a full-time student and primarily supported by the Employee;

(c) 19 or more years old and primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. At the time of claim under the policy for a child who is handicapped as defined in this paragraph, the policyholder must submit proof to the Insurance Company that the child is and has continued to be handicapped as defined by this paragraph.

The term child means a child born to the Employee and a child legally adopted by the Employee. It also means a step-child of the Employee living with the Employee.

Anyone who is eligible for the insurance as an Employee will not be considered as a Dependent.

No one may be considered as a dependent of more than one Employee.

[Section 4 4-2]

HOSPITAL CONFINEMENT OF CONFINED IN A HOSPITAL. A person will be considered confined in a Hospital if he is:

(1) a registered bed patient in a hospital upon the recommendation of a Physician;

(2) an out-patient in a hospital because of surgery; or

(3) receiving emergency care in a hospital for an Injury on his first visit as an out-patient within 72 hours after the Injury is received.

HOSPITAL. The term Hospital means:

(1) an institution licensed as a hospital, which:

(a) maintains, on the premises, all facilities necessary for medical and surgical treatment; and facilities controlled by the hospital;

(b) provides such treatment on an in-patient basis, for compensation, under the supervision of Physicians; and

(c) provides 24-hour service by Registered Graduate Nurses; or

(2) an institution which qualifies as a hospital, a psychiatric hospital, a tuberculosis hospital, a provider of rehabilitative services and a provider of services under Medicare, if such institutions is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Hospital Association, or the Commission on the Accreditation of Rehabilitative Facilities.

(3) an Ambulatory Surgical Center.

The term Hospital will not include:

(a) an institution which is primarily a place for rest, a place for the aged, a place for the treatment of alcohol or drug abuse, or a nursing home;

(b) any part or unit of a hospital which qualifies as a convalescent hospital.

[Section 4 4-3]

PARTICIPATING HOSPITAL. The term Participating Hospital means a hospital which has signed a participation agreement with the Insurance Company. A complete list of Participating Hospitals will be provided to each covered employee by the Insurance Company.

AMBULATORY SURGICAL CENTER. The term Ambulatory Surgical Center means a licensed public or private institution which:

(1) is operated by Physicians and a medical staff including Registered Graduate Nurses;

(2) has permanent facilities equipped and operated primarily for performing Surgical Procedures; and

(3) provides continuous Physician services on an out-patient basis.

BED AND BOARD. The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients. Charges for Bed and Board up to the hospital's semi-private room rate will qualify as Covered Expenses.

NECESSARY SERVICES AND SUPPLIES. The term Necessary Services and Supplies refers to services and supplies ordered by a Physician and customarily recognized in the Physician's profession as appropriate in the treatment of the patient's diagnosed sickness or injury. It includes:

(1) any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;

(2) any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and

(3) any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

PARTIAL HOSPITALIZATION SERVICES. The term Partial Hospitalization Services is defined as those services offered by a program accredited by the Joint Commission on Accreditation of Hospitals or in compliance with equivalent standards. Alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Hospitals or approved by the state and licensed drug abuse rehabilitation programs shall also be considered Partial Hospitalization Services.

NURSE. The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.", "L.P.H.", or "L.V.N.".

PERSONAL EXPENSE LIMIT. The personal expense limit is the amount of Covered Medical expense that must be paid by each person or family in a calendar year.

PHYSICIAN. The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to

perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

(1) operating within the scope of his license; and

(2) performing a service for which benefits are provided under this plan when performed by a Physician.

PSYCHOLOGIST. The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include another licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

(1) operating within the scope of his license; and

(2) performing a service for which benefits are provided under this plan when performed by a Psychologist.

(Continued)

SPECIAL CARE FACILITY. The term Special Care Facility means a licensed institution (other than a Hospital, as defined) which:

(1) specializes in physical rehabilitation;

(2) qualifies as a skilled nursing facility and a provider of services under Medicare;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

MEDICAID. The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

MEDICARE. The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

REASONABLE AND CUSTOMARY CHARGE. A charge will be considered Reasonable and a Customary if: (1) it is the normal charge made by the provider for a similar service or supply; and (2) it does not exceed the normal charge made by most providers of such service or supply in the locality where the service or supply is received. To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

EXPENSES INCURRED. An expense is incurred when the service or the supply for which it is incurred is provided.

INJURY. The term Injury means an accidental bodily injury.

SICKNESS. The term Sickness means a disease or illness, including pregnancy and complications of pregnancy, alcoholism, drug abuse, mental or nervous disorders and medical complications arising from an abortion.

(Continued)

HOME HEALTH CARE PLAN. The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

HOME HEALTH CARE AGENCY. The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

(1) primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;

(2) is run according to rules established by a group of professional persons;

(3) maintains clinical records on all patients;

(4) does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

HOME HEALTH AIDE. The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

EMPLOYEE INSURANCE ELIGIBILITY

Each Employee in one of the Classes of Eligible Employees shown below will become eligible for Employee Insurance on the day he completes the Waiting Period, if any. Any Employee who was previously insured and whose insurance ceased must satisfy the New Employee Group Waiting Period to become insured again. If the Insurance on an Employee ceased because he was no longer employed in a Class of Eligible Employees, he is not required to satisfy any Waiting Period if he again becomes a member of a Class of Eligible Employees within one year after his insurance ceased.

INITIAL EMPLOYEE GROUP. The Initial employee Group is made up of Employees: (1) in the employ of an Employer on the Effective Date of the policy; and (2) were insured under the group medical plan, if any, which was in effect on the day immediately preceding the effective day of this plan; or (3) in the employ of an Employer on the date that Employer becomes an Affiliated Employer.

NEW EMPLOYEE GROUP. The New Employee Group is made up of Employees not in the Initial Employee Group.

WAITING PERIOD

Initial Employee Group:	None
New Employee of the Group:	Ninety (90) days of full-time employment

AFFILIATED EMPLOYERS

Resorts Marketing, Inc.
Sahara Resorts, Inc.

CLASSES OF ELIGIBLE EMPLOYEES

All full-time Non-union Employees

[Section 5 (NV-Rev. 8-84) 5-1]

Each Employee will become eligible for Dependent Insurance on the latest date below:

(1) the date he becomes eligible for Employee Insurance;

(2) the date he acquires his first Dependent;

(3) the effective date of Dependent Insurance.

[Section 5 5-2]

Each Employee may elect to be insured for Employee Insurance only by signing a payroll deduction form approved by the Policyholder and the Insurance Company. The effective

date of his insurance depends upon the date on which the Employee elects the insurance.

(1) If he elects Employee Insurance on or before the date he becomes eligible, his insurance will become effective on the first day of the month after he becomes eligible.

(2) If he elects Employee Insurance within 31 days after he becomes eligible, his insurance will become effective on the first day of the month after he becomes eligible or on the date of election, whichever is later.

(3) If he elects Employee Insurance more than 31 days after he becomes eligible, his insurance will become effective on the date the Insurance Company agrees in writing to insure him.

(4) If his Employee Insurance ceased because he cancelled his payroll deduction, and he again elects to be insured, his insurance will become effective on the date the Insurance Company agrees in writing to insure him.

Under the circumstances described in items 3 and 4, the Insurance Company may require the Employee to submit evidence of good health acceptable to the Insurance Company at his own expense before it agrees to insure him.

If an Employee is not in Active Service on the date his insurance would otherwise become effective, it will become effective on the date he returns to Active Service.

[Section 6 6-1]

Each Employee may elect to be insured for Dependent Insurance only by signing a payroll deduction form approved by the Policyholder and the Insurance Company. The effec-

tive date of insurance for each Dependent depends upon the date on which the Employee elects Dependent Insurance.

(1) If the Employee elects Dependent Insurance on or before the date he becomes eligible for it, the insurance for each Dependent will become effective on the first day of the month after the Employee becomes eligible for it.

(2) If the Employee elects Dependent Insurance within 31 days after he becomes eligible for it, the insurance for each Dependent will become effective on the first day of the month after he becomes eligible or on the date of election, whichever is later.

(3) If the Employee elects Dependent Insurance more than 31 days after he becomes eligible for it, the insurance for each Dependent will become effective on the date the Insurance Company agrees in writing to insure the Dependent.

(4) If the Employee's Dependent Insurance ceased because he cancelled his payroll deduction, and he again elects to be insured for it, the insurance for each Dependent will become effective on the date the Insurance Company agrees in writing to insure the Dependent.

Under the circumstances described in items 3 and 4, the Insurance Company may require the Employee, at his own expense, to submit evidence of the Dependent's good health before it agrees to insure the Dependent.

If a Dependent is a patient in a Hospital on the date his insurance would otherwise become effective, the effective date of his insurance will be postponed until the day after he is discharged from the Hospital.

An Employee will be insured for Dependent Insurance only if he is insured for Employee Insurance.

Any reference to an insured Dependent means a Dependent for whom the Employee is insured.

EXCEPTIONS FOR NEWBORNS. Any Dependent child born while the Employee is insured for Dependent Insurance will be insured from the date of birth. A Dependent child born while the Employee is insured for himself, but not for his Dependents, will become insured on the date of the child's birth, if the Employee elects Dependent Insurance no later than 31 days after the child's birth.

[Section 6 6-2]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

If an Employee or a Dependent incurs Covered Expenses while insured for Comprehensive Medical Benefits under this policy, the Insurance Company will pay benefits as follows, subject to the Benefit Maximums, Co-payment and after any Deductible shown in the Schedule:

(a) [80%] of all Covered Expenses incurred, except that if such Covered Expenses are incurred in a Participating Hospital, the Insurance Company will pay [90%] of those Covered Expenses. If such Covered Expenses are incurred in a Non-Participating Hospital, the Insurance Company will pay [70%] of those Covered Expenses; however,

(b) the Non-Participating Hospital Deductible shown in the Schedule will first be deducted from such Covered Expenses for each admission or outpatient surgical visit in a Non-Participating Hospital and is exclusive of any Personal Expense Limit provisions; except

(c) when an amount equal to the Calendar Year Deductible for each person, if any, has been satisfied in a calendar year, the difference between the Calendar

Year and Non-Participating Hospital Deductibles will be deducted for each admission or outpatient surgical visit in a Non-Participating Hospital and is exclusive of any Personal Expense Limit provisions.

FULL PAYMENT AREA FOR COVERED EXPENSE INCURRED. After a covered person has incurred [$1,000] of expense for covered charges or a family has incurred [$3,000] expense for covered charges during a calendar year, excluding expenses used to satisfy the deductible provisions of the policy, benefits for that person or family will be paid at 100% for the balance of the calendar year. However, benefits for expenses incurred for that person for or in connection with Mental Illness, Alcoholism and Drug Dependency while not confined in a hospital will continue to be payable as provided in the Schedule.

MAXIMUM BENEFIT PROVISION. The total amount of Comprehensive Medical Benefits payable for all expenses incurred for an Employee or Dependent in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

However, once a person uses any portion of his Maximum Benefit, on each January 1st the Insurance Company will reinstate the used amount up to $1,000 to be applied to Covered Expenses incurred after the date of reinstatement.

At any time after the benefits charged to an individual's overall maximum reach a total of at least $1,000, the full maximum will be reinstated upon submission to the Insurance Company of satisfactory proof that the individual is in good health.

[Section 7 (NV-Rev. 8-84) 7-1]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

MENTAL ILLNESS MAXIMUM. The total amount of Comprehensive Medical Benefits payable for all expenses incurred for an Employee or Dependent in a calendar year for or in connection with mental illness while he is not Confined in a Hospital will not exceed the Mental Illness Maximum shown in The Schedule. The maximum number of visits covered for treatment of mental illness while not confined in a hospital is fifty in one calendar year.

MENTAL ILLNESS BENEFIT. The total amount of Comprehensive Medical Benefits payable for an inpatient hospital patient for mental and nervous disorders will be thirty days per benefit year.

MENTAL ILLNESS PARTIAL HOSPITALIZATION. If partial hospitalization services or a combination of inpatient and partial hospitalization are utilized under the direction of a licensed physician, the total benefit paid for all such services shall not exceed the cost of thirty days of inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered.

SPECIAL CARE FACILITY MAXIMUM. The total amount of Comprehensive Medical Benefits payable for all expenses incurred for an Employee or a Dependent in a calendar year for charges made by a Special Care Facility will not exceed the Special Care Facility Maximum shown in The Schedule.

ALCOHOLISM AND DRUG ABUSE. Benefits will be provided for treatment provided by or under the supervision of or prescribed by a licensed physician or licensed psychologist if such services are provided in a program accredited by the Joint Commission on Accreditation of Hospitals or approved by the state. The total payment for such benefits will not exceed the inpatient and outpatient Drug and Alcohol course of treatment maximums shown in The Schedule.

PRE-EXISTING CONDITION BENEFIT FOR PERSONS INSURED AFTER THE INITIAL GROUP. The Insurance Company will pay up to a maximum of two thousand dollars for covered charges incurred for the treatment of a condition which existed prior to the date insured for these benefits. The deductible shown in The Schedule will not apply to this benefit.

[Section 7 7-2]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

COVERED EXPENSES. The term Covered Expenses means the expenses incurred by or on behalf of an Employee or a Dependent for the Charges listed below, if they are incurred after such person becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or a Sickness. The following paragraphs describe the Covered Expenses.

(1) charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies, provided that charges for Bed and Board do not exceed the Hospital's semi-private room rate.

(2) charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

(3) charges made by a Surgeon or Assistant Surgeon for the following professional services:

(a) the immediate pre-operative examination by the doctor performing the procedure.

(b) performance of the procedure.

(c) assistance with the procedure where required by the nature of that procedure or by the patient's condition, provided it is not performed in a hospital having available staff physicians qualified to provide such assistance.

(4) charges made for the following services while being hospital confined: anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration.

(5) charges for eligible expenses relating to an accident and incurred within 90 days of that accident and follow-up care. Charges incurred after 90 days will be treated as any other illness to the extent covered by the policy.

[Section 7 7-3]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

(6) charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient, except for charges relating to an accident and incurred with 90 days will be treated as any other illness to the extent covered by the policy.

(7) charges made by a Special Care Facility, on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion of such charges for any one day which is more that the Special Care Facility Daily Limit shown in The Schedule.

(8) charges made by a Physician or a Psychologist for professional services.

(9) charges made by a Nurse, other than a member of the Employee's or Dependent's family, for professional nursing services.

(10) charges made for the following services in a physician's office or on an outpatient basis: X-ray, radium and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental or, at the Insurance Company's option, purchase of durable equipment which is solely used for a medical purpose; physical therapy by a licensed physical therapy by a licensed physical therapist; purchase and fitting or prosthetic appliances; dressings; the first set of contact lenses or eyeglasses made necessary by cataract surgery.

(11) drugs and medicines lawfully dispensed only upon the written prescription of a Physician, excluding vitamins.

[Section 7 7-4]

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

(12) dentist's charges for surgical removal of an impacted tooth, up to the following maximum charge level:

Impacted tooth, one, excision of - (soft tissue impactions excepted)	Maximum Charges

Partially unerupted from jaw bone -	
Maxilla	$18.00
Mandible	30.00
Completely unerupted from jaw bone	60.00

When two or more impacted teeth are excised during the same operative session, the maximum charges for all such excisions shall be limited to the sum of (i) the largest Maximum Payment otherwise applicable to one of the excisions and (ii) 50% of the maximum payment otherwise applicable to each of the other excisions.

(13) convalescent nursing home charges for confinement after a covered hospital stay of at least three consecutive days. The confinement must start within fifteen days after release from the hospital and be prescribed by a doctor for the condition which caused hospitalization.

(14) charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan:

(a) part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

(b) part-time or intermittent services of a Home Health Aide;

(c) physical, occupational or speech therapy;

(d) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had the Employee or

Dependent required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

[Section 7 7-5]

excluding any charges for:

(a) more than 40 home health care visits during a calendar year; (to determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit.);

(b) care or treatment which is not stated in the Home Health Care Plan;

(c) the services or a person who is a member of the Employee's or Dependent's family or who normally lives in the Employee's or Dependent's home;

(d) a period when the Employee or Dependent is not under the continuing care of a physician.

(15) Charges for two prosthetic devices and reconstructive surgery incident to a mastectomy. Charges for reconstructive surgery which begins more than three years after a mastectomy shall be subject to all the terms, conditions and exclusions in the policy at the time of such surgery.

(16) Services rendered by a Hospice shall be on the same basis as any other health care provider services covered by the policy, provided, the Hospice meets the standards and any licensing requirement of the state of locality in which it operates.

[Section 7 7-6]

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

EXPENSES NOT COVERED. Covered Expenses will not include, and no payment will be made for, expenses incurred:

(1) for that portion of charges made for any one day for hospital bed and board which exceed the hospital's semi-private room rate.

(2) for that portion of charges made for any one day for or in connection with mental illness, while the Employee or Dependent is not Confined in a Hospital, which is more than the Mental Illness Daily Limit shown in The Schedule.

(3) for or in connection with cosmetic surgery unless (a) the Employee or Dependent receives an Injury, while insured for these benefits, which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on the Employee or Dependent following surgery are medically necessary; or (c) it is required to provide; or restore a normal bodily function.

(4) for eyeglasses, hearing aids or examinations for prescription or fitting thereof.

(5) for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for or in connection with dental work due to an Injury to sound natural teeth sustained while the Employee or Dependent is insured for these benefits; or (b) charges made by a Hospital for Bed

and Board or Necessary Services and Supplies; or (c) charges made by a Physician for a Surgical Procedure.

(6) for which benefits are not payable according to the "General Limitations" section.

(7) for or in connection with an Injury or sickness which is more than the Pre-existing Condition benefit shown in The Schedule unless those expenses are incurred after the earlier of: (a) a 90-day period, which ends while the Employee or Dependent is insured for these benefits, during which he receives no treatment, incurs no expenses and receives no diagnosis from a Physician in connection with that Injury or Sickness; or (b) a one-year period during which such Employee or Dependent is continuously insured for these benefits.

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

PRE-EXISTING CONDITION. A Pre-existing Condition is an Injury or a Sickness for which an Employee or a Dependent receives treatment, incurs expenses or receives advice from a Physician during the 90 days prior to the date such Employee or Dependent becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness.

COMMON ACCIDENT. If an Employee and one or more of his insured Dependents or if two or more of his insured Dependents are injured in the same accident and incur Covered Expenses for those injuries in the calendar year in which the accident occurs, not more than one Comprehensive Medical Deductible will be deducted from the total

Covered Expenses incurred for those persons during the rest of that calendar year.

MULTIPLE BIRTH. Not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred in a calendar year for two or more Dependents born in a multiple birth if those Covered Expenses are incurred in the same calendar year in which they are born and are due to:

(1) premature birth;

(2) abnormal congenital condition; or

(3) Injury which is received or Sickness which starts not more than 30 days after their birth.

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

SECOND OPINION SURGICAL BENEFITS. If, as a result of an Injury or a Sickness, an Employee or a Dependent, while insured for these benefits and prior to the performance of an Elective Surgical Procedure recommended by a surgeon, asks for an opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness, the Insurance Company will pay 100% of the Covered Expenses incurred for the fee charges for that opinion. If the Employee or Dependent incurs Covered Expenses for additional diagnostic laboratory or X-ray examinations not previously requested and asked for by the Physician who gives that opinion, the Insurance Company will pay 100% of the Covered Expenses so incurred.

THIRD OPINION SURGICAL BENEFITS. If the first and second opinion for elective surgery conflict and the Employ-

ee or Dependent asks for a third opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness, the Insurance Company will pay 100% of the Covered Expense incurred for the fee charged for the third opinion. If the Employee or Dependent incurs Covered Expenses for additional diagnostic laboratory or X-ray examinations not previously requested and asked for by the Physician who gives the third opinion, the Insurance Company will pay 100% of the Covered Expenses.

Payment will be made whether or not the Surgical Procedure is performed.

Payment will be subject to all terms of the policy except as otherwise provided in this section.

The benefits described above are not subject to the Comprehensive Medical Deductible.

LIMITATIONS. No payment will be made for expenses incurred in connection with:

(1) cosmetic or dental Surgical Procedures not covered under the policy;

(2) minor Surgical Procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions;

(3) an opinion obtained more than 6 months after a surgeon has recommended the Elective Surgical Procedure.

Other Limitations are shown in the "General Limitations" section.

No payment will be made under any other section of the policy for expenses incurred to the extent that benefits are payable for those expenses under this section.

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

ELECTIVE SURGICAL PROCEDURE. The term Elective Surgical Procedure means a Surgical Procedure which is not considered emergency in nature and which may be avoided without undue risk to the individual.

OUTPATIENT PRE-ADMISSION TESTING BENEFITS. If an Employee or Dependent, while insured for these benefits immediately prior to being admitted as an inpatient and prior to the performance of a surgical procedure recommended by a Surgeon, incurs Covered Expenses for diagnostic laboratory or X-ray examinations asked for by the Surgeon, and these examinations are performed on an outpatient basis before being admitted to the Hospital, the Insurance Company will pay 100% of the Covered Expenses so incurred.

Payment will be made whether or not the surgical procedure is performed. Payment will be subject to all terms of the policy except as otherwise provided in this section.

The benefits described above are not subject to the Comprehensive Medical Deductible.

LIMITATIONS. No payment will be made under any other section of the policy for expenses incurred to the extent that benefits are payable for those expenses under this section.

INSURING PROVISIONS

SPECIAL PROVISIONS FOR NEWBORN DEPENDENT MEDICAL BENEFITS

EFFECTIVE DATE OF INSURANCE. Any Dependent child born while the Employee is insured for Dependent Insurance will be insured from the moment of birth. A Dependent child born while the Employee is insured for himself but not for his Dependents, will become insured from the moment of birth if the Employee elects Dependent Insurance no later than 31 days after the child's birth.

BENEFITS PAYABLE. If a Newborn Dependent, while insured, incurs expenses as a result of an Injury or Sickness, the Insurance Company will pay for those expenses to the same extent as those payable for any other insured Dependent. Benefits will also be payable for transportation charges to and from the nearest available facility staffed and equipped to treat the Newborn Dependent's condition. The transportation must be certified by a Physician as medically necessary. The maximum amount payable for transportation charges for a Newborn Dependent will be no less than $1,000.

In addition to the above, expenses incurred for routine care of the Newborn Dependent prior to the date of discharge from the Hospital nursery will be deemed to result from a Sickness.

SICKNESS. Sickness also includes medically diagnosed congenital defects, birth abnormalities or Premature Birth.

PREMATURE BIRTH. Premature Birth means a child born too early as determined by a Physician.

LIMITATIONS. No payment will be made:

(1) for expenses incurred for transportation charges made in connection with routine care of a Newborn Dependent;

(2) under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

Other Limitations are shown in the "General Limitations" section.

[Section 7 7-10]

INSURING PROVISIONS

CHANGE OF INSURER. When this plan replaces a prior medical policy of the Employer, the following applies to Covered Members who:

(1) Were insured by the prior plan on the day before this plan was issued and

(2) Became a member on the first day under this plan.

Coverage is effective whether or not the Employee is actively working or the Dependent is confined to a hospital on that date.

The Pre-Existing conditions limitations will be modified as follows:

(1) If the Pre-Existing Conditions Limitation is satisfied, expenses will be covered under this plan; or

(2) If the Pre-Existing Conditions Limitation is not satisfied, benefits may still be payable, subject to the following:

(a) if the pre-existing limitation of the prior plan was satisfied when that plan terminated, benefits will be provided for the pre-existing condition. The amount of Covered Expense will be the lesser of the prior plan's benefits or the benefits under this policy; or

(b) if the pre-existing limitations of the prior plan had not been satisfied when that plan terminated,

Members will be permitted to satisfy that limitation while covered under this plan. However, any benefits payable due to a pre-existing condition prior to satisfying that Pre-Existing Conditions Limitation under this plan, will be the lesser of the prior plan's benefits or the benefits under this plan.

If the Employee is totally diabled, or any Dependent is hospital confined on the first day of the plan subject to the Pre-Existing Conditions limitations:

(1) Coverage for the condition causing the total disability or hospital confinement will begin after coverage under the prior plan ends;

(2) Coverage for all other conditions will begin on the effective date of this plan; and

(3) Coverage will continue for all conditions for the period of the prior plan's extended benefits, or 12 months after disability begin, whichever comes first.

[Section 7 (NV-Add 8/84) 7-11]

INSURING PROVISIONS

(Continued)

CHANGE OF INSURER DEDUCTIBLE CREDIT. The amount of the Major Medical Deductible may be reduced if the Employee became insured by this policy on its effective date, and; had been insured by the prior plan of group medical insurance on the day before this policy takes effect.

If these two requirements are met, the Insurance Company will reduce the deductible by any amount of covered expenses incurred under the prior plan which were applied to that plan's deductible.

[Section 7 (NV-Add 8/84) 7-12]

GENERAL LIMITATIONS

No payment will be made for expenses incurred:

(1) for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;

(2) for or in connection with a Sickness which is covered under any workers' compensation or similar law;

(3) for charges made by a Hospital owned or run by the United States Government unless the Employee or Dependent is legally required to pay for such charges;

(4) to the extent that payment is unlawful where the Employee or Dependent resides when the expenses are incurred;

(5) for charges which the Employee or Dependent is not legally required to pay;

(6) for charges which would not have been made if the Employee or Dependent had no insurance;

(7) to the extent that they are more than Reasonable and Customary charges;

(8) for charges for unnecessary care, treatment or surgery;

(9) for or in connection with custodial care, education or training;

(10) to the extent that the Employee or Dependent is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

(11) for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by Federal law to investigational use," except that in the case that such drugs or substances become approved by the Food and Drug Administration, they will be covered from that time on;

(12) for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society, except that in the case that such procedures or methods become approved by the American Medical Association or the appropriate medical specialty society, they will be covered from that time on.

GENERAL LIMITATIONS

(Continued)

No payment will be made for expenses incurred by an Employee or a Dependent:

(1) To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

(a) a "no-fault" insurance law; or

(b) an uninsured motorist insurance law.

The Insurance Company will take into account any adjustment option chosen under such part by the Employee or Dependent.

(2) For or in connection with an elective abortion unless:

(a) the Physician certifies in writing that the pregnancy would endanger the life of the mother; or

(b) the expenses are incurred to treat medical complications due to the abortion.

The Medical Expense Insurance for an Employee or a Dependent who is age 65 or older and eligible for Medicare will be modified as follows:

(1) If expenses are incurred for which benefits are payable under both this plan and Part A of Medicare, benefits will be payable under this plan only for those expenses so incurred which exceed the amount payable under Part A of Medicare.

(2) The amount payable under this plan for expenses in curred for which benefits are payable under both this plan and Part B of Medicare will be reduced by the amount payable for those expenses under Part B of Medicare.

(3) The deductible will apply only to Covered Expenses incurred for prescription drugs and charges made by a Nurse.

For an Employee or a Dependent who is less than age 65 and eligible for Medicare, the amount payable under this plan will be reduced so that the total amount payable by the Insurance Company and Medicare will be no more than 100% of the expenses incurred.

The Insurance Company will assume the amount payable under Part B of Medicare for any person who is eligible to enroll in that Part, but did not, to be the amount he would receive if he had enrolled.

A person is considered eligible for Medicare on the earliest date coverage under Medicare could become effective for him.

Where applicable due to the Tax Equity and Fiscal Responsibility Act of 1982 actively working employees ages 65 to 69 may elect one of the following options:

(1) Medical benefits under this plan will be paid first (primary). The the benefits of Medicare will be paid second (secondary). The option elected by the Employee will also apply to the employee's spouse age 65 to 69; or

(2) Medicare benefits only. The employee (and his dependents, if any) will not have coverage under this plan.

The employer must provide each actively working employee with the opportunity to elect one of these options at least one month prior to the month in which the employee becomes age 65. All new employees aged 65 to 69 must be permitted to elect an option when hired.

If medical coverage under this plan is elected (Option 1), its issue will be subject to the same requirements as for an employee or dependent under age 65.

A spouse aged 65 to 69 of an actively working employee who is under age 65, or age 70 or older, will receive benefits payable by Medicare before any benefits payable under this plan. The benefits of the plan will be reduced for a Medicare benefit the person is entitled to receive (including Part B), whether or not Medicare coverage has been applied for.

[Section 9 (NV-Rev. 8/84) 9-1]

MEDICARE ELIGIBLES

(Continued)

An actively working employee aged 70 and older, or a spouse aged 70 and older, or retired employees and their spouses, will receive benefits payable under Medicare before any medical benefits payable under this plan. The benefits of this plan will be reduced for any Medicare benefit the person is entitled to receive (including Part B), whether or not Medicare coverage has been applied for.

An employee's dependents (other than a spouse) who are eligible for Medicare will receive benefits payable under Medicare before any medical benefits payable under this plan. The benefits of this plan will be reduced for any

Medicare benefit the person is entitled to receive (including Part B), whether or not Medicare coverage has been applied for.

[Section 9 (NV-Rev. 8/84) 9-2]

CO-ORDINATION OF BENEFITS

If a person covered under this policy (called "this Plan") is also covered under one or more other Plans, the benefits payable for him from this Plan will be co-ordinated with the benefits payable for him from all other Plans.

Co-ordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of (a) and (b) below would exceed those Allowable Expenses:

(a) the benefits that would be payable from this Plan without co-ordination; and

(b) the benefits that would be payable from all other Plan without Co-ordination of Benefits provisions in those Plan.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period without Co-ordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans

will not exceed the total of those Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

[Section 10 10-1]

CO-ORDINATION OF BENEFITS

(Continued)

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if:

(a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and

(b) the other Plan has a provision that co-ordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

When Co-ordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a person covered under this Plan, each benefit that would be payable in the absence of Co-ordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of this Plan.

The Insurance Company reserves the right to release to or obtain from any other insurance company or other organization or person any information which, in its opinion, it needs for the purpose of Co-ordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, the Insurance Company will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. The Insurance Company will be released from all liability under this Plan to the extent of these payments.

When an overpayment has been made by the Insurance Company, at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as it may determine.

CO-ORDINATION OF BENEFITS

(Continued)

BENEFIT DETERMINATIONS RULES. The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a male will be determined before a Plan which covers that person as a dependent of a female; except that, in the case of a dependent child of divorced or separated parents, the following rules will apply.

If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covered the child as a dependent of the parent of the parent with custody will be determined before a Plan which covers the child as dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

(3) When the above rules do not establish the order, the benefits of a Plan which has covered the person for

whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; provided that:

(a) the benefits of a Plan covering the person on whose expenses claim is based as laid-off or retired employee or as the dependent of such person shall be determined after the benefits of any other Plan covering such person as an employee other than as a laid-off or retired employee or a dependent of such person; and

(b) if either Plan does not have a provision regarding laid-off or retired employees, and, as a result, each Plan determines its benefits after the other, then the provisions of (a) above shall not apply.

CO-ORDINATION OF BENEFITS

(Continued)

DEFINITIONS

PLAN. Plan means any:

(1) group insurance coverage;

(2) service plan contracts, group of individual practice or other prepayment plans; or

(3) coverage under any labor-management trusteed plans, union welfare plans, employer organizations plans, or employee benefit organization plans;

which provides medical or dental benefits or services. It does not include coverage under individual or franchise policies or contracts.

Each Plan or part of a Plan which has the right to co-ordinate benefits will be considered a separate Plan.

ALLOWABLE EXPENSE. Allowable Expense means any necessary, reasonable and customary item of expense at least a part of which is covered by any one of the Plans that covers the person for whom claim is made.

When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

CLAIM DETERMINATION PERIOD. Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

PAYMENT OF CLAIMS

TO WHOM PAYABLE: All medical benefits are payable to the Employee. However, with the consent of the Insurance Company and the Policyholder, an insured may direct that all or any part of the medical benefits may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give valid receipt for any payment due him, such payment will be made to his legal guardian. However, if no request for payment has been made by his legal guardian, the Insurance Company may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

The Insurance Company will pay benefits for covered services after the insured person has satisfied the deductible and other co-insurance amounts he is obligated to pay. Obligated to pay means the amount of charges the insured employee or his dependents must pay. It does not include any charges which are discounted, rebated or waived. The amount of any discount, rebate, waived charges or charges the insured

employee or his insured dependents are not obligated to pay shall not be considered covered charges under this contract. The Insurance Company shall have the right to recover from a provider of services or insured employee any excess benefit payments made as a result of a discount, rebate, waived charges or charges the insured employee or his insured dependents are not obligated to pay.

If an Employee dies while medical benefits remain unpaid, the Insurance Company may choose to pay benefits up to $3,000 to a person or persons related to the Employee by blood or marriage who appears to be entitled to the benefits; or the executors of administrators of the Employee's estate. The Insurance Company will be discharged to the extent of any such payment made in good faith.

TIME OF PAYMENT OF CLAIMS. Medical benefits will be paid by the Insurance Company when it receives proper written proof of loss.

SUBROGATION. In the event of any payment for benefits provided to an insured under this policy, the Insurance Company, to the extent of such payment, shall be subrogated to all rights of recovery such insured has against any person or organization. The insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Insurance Company. Where state law eliminates the insureds right to recover amounts received from collateral sources, this provision shall not apply and the Insurance Company shall have no right to subrogation or indemnification against any person or organization and shall not require that the insured execute or deliver any instrument or paper in order to protect or secure subrogation or recovery rights to the Insurance Company.

In the event the insured person initiates action and makes recovery from any person or organization, the amount due

the Insurance Company will be subject to a pro-rata share of attorney fees.

[Section 11 (NV-Rev. 8/84) 11-1]

TERMINATION OF INSURANCE

For Employees

The insurance on an Employee will cease on the earliest date below:

(1) the date the Employee ceases to be in a Class of Eligible Employees or ceases to qualify as an Employee;

(2) the last day for which the Employer has made any required contribution for the insurance;

(3) the date the policy is cancelled;

(4) the date the Employee's Active Service ends, except as set forth below.

TEMPORARY LAYOFF OR LEAVE OF ABSENCE. If an Employee's Active Service ends due to temporary layoff or leave of absence, the insurance will be continued until the Policyholder stops paying premium for the Employee or otherwise cancels the insurance. However, the insurance will not continue for more than 60 days past the date the Employee's Active Service ends.

INJURY OR SICKNESS. If an Employee's Active Service ends due to an Injury or a Sickness, the insurance will be continued for up to 12 months during disability leave or absence while the Employee remains totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date the Policyholder stops paying premium for the Employee or otherwise cancels the insurance.

RETIREMENT. If an Employee's Active Service ends because he retires, the insurance will be continued until the

date on which the Policyholder stops paying premium for the Employee or otherwise cancels the insurance.

Any continuation of insurance must be based on a plan which precludes individual selection.

[Section 12 (NV-Rev. 8/84) 12-1

TERMINATION OF INSURANCE

(Continued)

For Dependents

An Employee's insurance for all of his Dependents will cease on the earliest date below:

(1) the date of the Employee's insurance for himself ceases, except in the case of death;

(2) the date the Employee ceases to be in a class of Employees eligible for Dependent Insurance;

(3) the last day for which the Employee has made any required contribution for Dependent Insurance;

(4) the date Dependent Insurance is cancelled.

An Employee's insurance for any one of his Dependents will cease on the date the Dependent no longer qualifies as a Dependent.

DEPENDENT MEDICAL INSURANCE AFTER EMPLOYEE'S DEATH. If an Employee is insured for Medical Expense Insurance when he dies, any of his Dependents who are then insured for Medical Expense Insurance, except a Dependent who is eligible for Medicare, will remain so insured without further payment of premiums for them. However, the insurance on any of those Dependents will cease on the earliest date below;

(1) the last day of the twelfth month after the Employee's death;

(2) the date of remarriage of a surviving spouse, if any;

(3) the date that Dependent qualifies for Medicare;

(4) the date that Dependent ceases to qualify as a Dependent for a reason other than last of primary support by the Employee.

The Dependent benefits payable after the Employee dies will be those in effect on his last day of Active Service.

[Section 12

12-2]

MEDICAL BENEFITS EXTENSION

If this policy terminates for the entire group, any expense incurred within 12 months after a persons's Comprehensive Medical Benefits cease will be deemed to be incurred while he is insured if such expense is for an Injury or a Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

TOTALLY DISABLES. An Employee will be considered Totally Disabled if, because of an Injury or a Sickness:

(1) he is unable to perform the basic duties of his occupation; and

(2) he is not performing any other work or engaging in any other occupation for wage or profit.

A Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

(1) he is unable to engage in the normal activities of a person of the same age, sex and ability; or

(2) in the case of a Dependent who normally works for wage or profit, he is not performing such work.

[Section 13 13-1]

MEDICAL CONVERSION PRIVILEGE

For Employees and Dependents

When an Employee's or a Dependent's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy or certificate of medical care benefits (called the Converted Policy) issued by the Insurance Company. A Converted Policy will be issued by the Insurance Company only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to the Insurance Company within 31 days after the date his insurance ceases. Evidence of good health is not needed. The Insurance Company will provide all necessary information to a person who is Entitled to Convert, so that application may be made.

EMPLOYEES ENTITLED TO CONVERT. An Employee is entitled to Convert Medical Expense Insurance for himself and all of his Dependents who were insured when his insurance ceased, provided such persons have been continuously insured for at least 3 months under this policy and any group policy providing similar benefits which it replaced, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

(1) The Employee's insurance ceased because he was no longer in Active Service or no longer eligible for Medical Expense Insurance.

(2) The Employee does not replace this group plan within 31 days by another group plan.

(3) The Employee is not eligible for Medicare.

(4) The Employee would not be Overinsured.

A retired Employee may apply for a Converted Policy within 31 days after his retirement date in place of any continuation of his insurance that may be available under this plan when he retires, if he is otherwise Entitled to Convert.

DEPENDENTS ENTITLED TO CONVERT. The following Dependents are also Entitled to Convert:

(1) a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of the Employee's death;

(2) a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or the Employee's death;

(3) the Dependents of an Employee, if the Employee is not Entitled to Convert solely because he is eligible for Medicare;

but only if that Dependent: (a) was insured when the Employee's insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

[Section 14 14-1]

MEDICAL CONVERSION PRIVILEGE

(Continued)

For Employees and Dependents

OVERINSURED. A person will be considered Overinsured if either (1) or (2) occurs:

(1) His insurance under this plan is replaced by similar group coverage within 31 days.

(2) The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on the Insurance Company's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy or a hospital or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan or group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

CONVERTED POLICY. An Employee entitled to a Converted Policy for himself and dependents will be entitled to a choice of 3 policies offering benefits on a expense incurred basis. The choice of policies offered will include a policy with the benefit level provided by this policy. The Insurance Company may provide a Medicare Supplement policy for a person eligible for Medicare.

The Converted Policy will be issued to the Employee if he is Entitled to Convert, insuring him and those Dependents for whom he may convert. If the Employee is not Entitled to Convert and his spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

MEDICAL CONVERSION PRIVILEGE

(Continued)

For Employees and Dependents

This Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

The Insurance Company or the Policyholder will give the Employee, on request, further details of the Converted Policy.

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the day of the month with the same number as the Anniversary Date of the last day of a month in which there is no day with the same number as the Anniversary Date.

MONTHLY STATEMENT DATE. The Monthly Statement Date will be the same as the Premium Due Date.

MONTHLY PREMIUM STATEMENT. A Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of insured persons and changes in insurance amounts that took place in the preceding month.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Monthly Statement Date that is the same as or next follows the date that (1), (2) or (3) below takes place:

(1) A person becomes insured.

(2) The amount of insurance on a person changes, but not due to a revision of The Schedule.

(3) A person ceases to be insured.

PREMIUMS

(Continued)

MONTHLY PREMIUM RATE. The monthly premium rate per Employee is as follows:

For Family Insurance
$113.00

CALCULATION OF PREMIUMS. The monthly premium will be calculated as follows:

(1) Multiply the number of Employees insured on the Premium Due Date in each rate class shown in the

"Monthly Premium Rate" section by the premium rate in effect on that date for that class.

(2) Add the results.

If the Policyholder and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 12 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period.

However, the Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If an increase in rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in rates takes place on a data that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this policy may be combined with the experience under other group insurance policies issued by the Insurance Company to the Policyholder. If the

Insurance Company grants a credit, the excess, if any, of the policyholder fund paid for the coverage including the cost of Administration, shall be applied for the benefit of insured employees or members.

[Section 15 (NV-Rev. 8-84) 15-2]

CANCELLATION OF POLICY

The Policyholder may cancel the policy as of any Premium Due Date by giving written notice to the Insurance Company before that date.

The Insurance Company may cancel the policy as of any Premium Due Date if the number of insured Employees is less than 25 or less than 75% of those eligible. Dependent Insurance may be cancelled as of any Premium Due Date if the number of Employees insured for their Dependents is less than 75% of those eligible.

If a premium is not paid when due, the policy will automatically be cancelled as of the Premium Due Date, except as set forth below.

GRACE PERIOD. If, before a Premium Due Date, the Policyholder has not given written notice to the Insurance Company that the policy is to be cancelled, a Grace Period of 31 days will be granted for the payment of each premium after the initial premium. The policy will stay in effect during that time. If any premium is not paid by the end of the Grace Period; except that, if the Policyholder has given written notice in advance of an earlier date of cancellation, the policy will be cancelled as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the policy was in force.

[Section 16 (NV-Rev. 8/84) 16-1]

PROVISIONS

EXECUTION OF POLICY. The policy is executed at the Home Office of the Insurance Company. The Post Office Address of the Insurance Company is 3201 South Maryland Parkway, Suite 118, Las Vegas, NV 89109.

CONSIDERATION. The policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA. The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other date that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has the right until all rights and obligations under the policy are finally determined.

INCORRECT PREMIUM PAYMENT. Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest when requested by the Policyholder. These premiums will not be refunded, however, for more than a 6-month period, nor for any period before the last Anniversary Date.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

[Section 17 17-1]

PROVISIONS

(Continued)

ENTIRE CONTRACT. The entire contract will be made up of the policy, the application of the Policyholder, a copy of

which is attached to the policy and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary or Assistant Secretary. No agent may change or waive any terms of the policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonable possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for claimant, the claim forms it used for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof or loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS Written proof of loss must be given to the Insurance Company within 90 days after the date of the

loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICIAN EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

[Section 17 17-2]

PROVISIONS

(Continued)

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the policy until at least 60 days after written proof of loss has been filed with the Insurance Company. No action may be brought after expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

PHYSICIAN/PATIENT RELATIONSHIP. The Employee will have the right to choose any physician who is practicing legally. The Insurance Company will in no way disturb the physician/patient relationship.

CERTIFICATES. The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate

will show the benefits provided under the policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the certificate will change or void the terms of the policy.

[Section 17 17-3]

MEDICAL QUALITY COST MANAGEMENT RIDER

PRE-ADMISSION REVIEW

A physician must obtain prior verification from us that any non-emergency admission of an insured person to a hospital for surgical or medical care is medically necessary as defined by the Group Policy. If we determine that the admission is not medically necessary, but the insured person elects to receive the prescribed care, it will not be covered under the Group Policy.

If the physician does not contact us before the insured person is admitted, we will review the admission on the first working day following the admission. If we determine that the admission is not medically necessary, we will notify the insured person in writing that coverage will end in 24 hours. If the insured person chooses to remain in the hospital beyond that time, any expenses the insured person incurs will be his or her responsibility.

CONTINUED STAY REVIEW

We will review a stay after an insured person is admitted to the hospital. If continued stay in the hospital is determined not to be medically necessary, the insured person will be notified in writing that coverage will end in 24 hours. If the insured person chooses to remain in the hospital beyond that time, the insured person will have to pay any remaining expenses that he or she incurs.

SURGICAL NECESSITY

If a physician recommends that an insured person have elective, non-emergency surgery, the physician must obtain prior verification from us that the procedure is medically necessary. If we determine that the surgery is not medically necessary, or that it can be safely done on an outpatient basis, we will notify the insured person in writing. If the insured person elects to undergo a procedure that has not been verified as medically necessary, he or she will be responsible for any expenses incurred for or in connection with the surgery.

/s/ Alice F. Newton
Secretary

[HCP1-R5 85-7/PRE]

HUMANA HEALTH INSURANCE COMPANY OF NEVADA, INC.

ENDORSEMENT

This Endorsement is made a part of Group Policy 78274.

ACCIDENT BENEFIT. If an Employee or Dependent, as a result of Injury, incurs Covered Expenses in a Participating Hospital for treatment in a hospital emergency room within 72 hours of the onset of that injury, the Insurance Company will pay 100% of the first $500 of those Covered Expenses.

If an Employee or Dependent is admitted to a Non-Participating Hospital on an emergency basis, caused by an injury which is life threatening in nature, the benefits will be paid on the same basis as a Participating Hospital.

The benefits described above are not subject to a Deductible.

No payment will be made under any other section of the policy for expenses incurred to the extent that benefits are payable for those expenses under this section.

_____
Secretary

[HCP-84-HMM-1.4]

HUMANA HEALTH INSURANCE COMPANY
OF NEVADA, INC.

GROUP MEDICAL EXPENSE INSURANCE POLICY

PREMIUM COST AGREEMENT

This Agreement is attached to and becomes a part of the Group Medical Expense Insurance Policy issued to Sahara & Hacienda Hotels on Policy 78274.

This Rider is issued for a term of four (4) years beginning on the effective date of this Rider.

The first contract year is the year beginning on the effective date. The second, third and fourth contract years begins on the first, second and third anniversaries of the effective date, respectively.

Monthly Premium Rates

Plan Year	*Family*
1/01/85 - 12/31/85	$113.00

Humana Health Insurance Company of Nevada, Inc. guarantees the above premium structure from January 1, 1985 to January 1, 1986. It is further guaranteed that this premium will not increase by more than the Consumer Price Index in each of the following three years after the first year, provided that 75% of hospital services are obtained at Participating Hospitals. If less than 75% of hospital services are obtained

in Participating Hospitals in the first contract year, the premium for the second contract year will not increase by more than the Consumer Price Index percentage plus 5%. However, the total increase for the second contract year is guaranteed not to exceed 10%. If less than 75% of hospital services are obtained in Participating Hospitals in any contract year after the second, the premium for the following contract year will not increase by more than the Consumer Price Index percentage plus 5%.

The Consumer Price Index for all Urban Consumers (CPI-U) is the measure of the average change in prices over time in a fixed market basket of goods and services as published by the United States Department of Labor, Bureau of Labor Statistics for the United States as a whole.

HUMANA HEALTH INSURANCE COMPANY OF NEVADA, INC.	SAHARA & HACIENDA HOTELS
BY: /s/ Larry Cash Larry Cash Vice President	BY: /s/ Herman M. Peacock
DATE: 2-6-85	DATE: 2-26-85

[HCP-84-NV-1.1 (NV-Rev. 8-84)]

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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

AMENDED COMPLAINT AND JURY DEMAND

COME NOW, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq. and for their causes of action against Defendants complain, aver and allege as follows:

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, *et seq.*, the Employment Retirement Income Security Act ("ERISA"); these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc., under Section 4 and 16 of the Clayton Act (15 U.S.C. § § 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. § 1961 - 1968.. Subject matter jurisdiction is conferred upon this Court by 29 U.S.C. § 1132, 15 U.S.C. § 15 & 16, and 28 U.S.C. § 1337.

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 28 U.S.C. § 1391 and 29 U.S.C. § 1132.

3. Defendants above named maintain an office and transact business and may be found within the District of Nevada. The interstate trade and commerce involved and affected by the alleged violations of the antitrust laws is carried on, in part, within the District of Nevada.

PARTIES

4. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was

insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant Humana Health Insurance of Nevada, Inc., ("Humana-Insurance") through payroll deductions.

5. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana-Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Marrietta Cade was at all times relevant Humana-Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana-Insurance policy. Robert Cade was hospitalized at Humana Hospital Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

6. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and did make premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through November 9, 1986. Ms. Andrews, under the 20% co-payment provisions, was obligated to pay and did pay a portion of all of her hospitalization costs.

7. Plaintiff Mary Lou Buehler, 210 Meyers Avenue, Henderson, Nevada 89015, has been insured with Humana-Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in

October of 1988 Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her billings for those hospitalizations were $23,293.94 and $2,736.85, respectively. Under the co-payment provision of her policy she was obligated to pay 20% of the costs of her hospitalization. Ms. Buehler has paid a portion of the co-payment.

8. Plaintiff Helen Staves, 37 East Stewart, Unit 50, Las Vegas, Nevada 89110, has been insured with Humana-Insurance since July 1988. At all times relevant, Mrs. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana-Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital Sunrise. Pursuant to the co-payment provisions under her policy, she is required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Mrs. Staves paid her portion of the co-payment.

9. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana-Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987, Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana-Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital Sunrise At that time day surgery was performed and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

10. None of the individual Plaintiffs above-named were ever informed that Humana-Insurance was able to negotiate favorable hospitalization rates at Humana Hospital Sunrise or that Humana-Insurance negotiated such rates for itself.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. (''Best Glass''), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has utilized Humana-Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass' group number with Humana-Insurance is 8280[illegible]8351-001. When Best Glass first became an insured with Humana-Insurance, the rates were very reasonable, $64.23 per employee per billing period. In 1986 this rate increased by 3% and in 1987 the rate jumped 13%. Finally, in 1988, when Best Glass decided not to renew with Humana-Insurance, Humana-Insurance sought a premium increase of 41% to continue coverage of employees of Best Glass. At no time did Humana-Insurance ever inform Best Glass that it was able to negotiate favorable hospitalization rates for its employees using Humana Hospital Sunrise for hospitalizations or that Humana-Insurance negotiated such rates for itself.

12. Defendant Humana Health Insurance of Nevada, Inc. (''Humana-Insurance'') is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana-Insurance is wholly owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. (''Group Health''). Humana-Insurance markets and sells group health insurance through employee benefit plans to employees throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona and Utah.

13. Defendant Humana, Inc. (''Humana'') is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has for many years, been one of the largest owners and operators of acute care hospitals in

the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana-Sunrise Hospital in Las Vegas, Nevada. Although Humana-Sunrise Hospital was only one of Humana's 87 hospitals in 1986, according to Humana's 1986 report to its stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana Resources in 1986, Humana-Sunrise generated thirty eight percent (38%) of Humana's pre-tax profits.

14. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOE CORPORATIONS I through V, inclusive, are unknown to Plaintiffs at this time, who therefore sue said Defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each of said Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will seek leave to amend this Complaint to allege their true names and capacities when and as ascertained.

CLASS ACTION

15. By order of this Court on September 26, 1989 Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade, Mary Lou Buehler and Helen Staves (the ''Co-Payor Class'') were recognized as class representatives pursuant to Fed.R.Civ.Pro. 23(b)(3).

16. By order of this court on September 26, 1989, Plaintiff Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves and Searle Auto Glass, Inc. (the ''Anti-Trust Class'') were recognized as class representatives pursuant to Fed.R.Civ.Pro. 23(b)(3). This Anti-Trust Class consists of individuals or entities paying at least a portion of the Humana-Insurance premiums during the relevant times.

CLASS ACTION

FIRST CLAIM FOR RELIEF

(Breach of ERISA Fiduciary Duties;
Engaging in Prohibited Transactions;
and Retaining Excessive Compensation)

17. The Co-Payor class reasserts and realleges each and every allegation contained in paragraphs 1 through 16 of the Complaint as though fully set forth at this point.

18. The Co-Payor Class consists of employees obtaining health insurance benefits under the employee benefit plan as defined under 29 U.S.C. 1001 *et seq*.

19. The members of the Co-Payor Class incurred charges at Humana Hospital Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana-Insurance is the insurer of the members of the Co-Payor Class through its insurance plan, Humana Care Plus.

20. The Humana Care Plus policy required that each member of the Co-Payor Class pay 20% of hospital costs. Humana-Insurance agreed to pay the remaining 80% of the hospital charges. The Co-Payor Class believed, and their agreement with Humana-Insurance provided, that the members of the Co-Payor Class and Humana-Insurance would be paying their respective contractual percentage of the charges.

21. Humana and Humana-Insurance negotiated a secret agreement which greatly reduced or discounted hospital charges for Humana-Insurance patients incurring charges at Humana Hospital Sunrise which constitutes discretionary authority and discretionary control respecting management of the plan, discretionary authority and discretionary control respecting management or disposition of its assets, or discre-

tionary authority or discretionary responsibility in the administration of the plan. Humana-Insurance is a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

22. The agreement Humana-Insurance negotiated with Humana specifically provided for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate.

23. Humana-Insurance exercised discretionary authority during the aforementioned negotiations with Humana. The reduced or discounted hospital charges were a crucial part of the administration of the health care plan.

24. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced co-payments. 29 U.S.C. § 1004.

25. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to refund the discount of the reduced costs it was able to negotiate with Humana. 29 U.S.C. § 1104.

26. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by breaching its duty to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana-Insurance imprudently decided to retain the co-payment refunds it negotiated with Humana. Humana-Insurance received excessive compensation in violation of its fiduciary duties. 29 U.S.C. § 1104.

27. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including but not limited to, AB 289. 29 U.S.C. § 1104.

28. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by dealing with the assets of the plan in its own interest or for its own account. 29 U.S.C. § 1106.

29. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by acting on behalf of Humana whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana-Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana. 29 U.S.C. § 1106.

30. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by unlawfully receiving consideration for its own personal account in connection with a transaction involving the assets of the plan. 29 U.S.C. § 1106.

31. It would be wrongful for Humana-Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of Humana-Insurance's duties to the Co-Payor Class and agreement with the Co-Payor Class.

32. A constructive trust should be imposed on the Defendants which requires turnover of all monies obtained through the scheme described herein.

33. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

34. As a result of the Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit upon Defendant Humana-Insurance. Defendant Humana-Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana-Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of

the scheme, the Defendant Humana-Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

35. The acts and practices of Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana-Insurance.

36. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana-Insurance, but the Co-Payor Class cannot now measure the damages with sufficient specificity but estimate these damages to be in excess of $10,000,000.00.

37. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq., to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

SECOND CLAIM FOR RELIEF

(Anti-Trust)

38. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 37 of the Complaint as though fully set forth at this point.

39. This Premium-Payor Class consists of individuals or entities paying all or a portion of the Humana-Insurance premiums during the period 1985 to 1988, including but not limited to employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

40. Defendant Humana is in the business of owning and operating for-profit acute care health facilities. Humana owns and operates a for-profit acute care health facility named Humana-Sunrise Hospital which provides a full range of hospital services within Clark County, Nevada. Approximately sixty percent (60%) of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada were billed by Humana-Sunrise Hospital in the relevant time period. This percentage is, and at all times relevant hereto has been, the largest market share of any for profit acute care facility in Clark County, Nevada.

41. At all times relevant hereto, the hospital charges billed by Humana for hospitalization at Humana-Sunrise were anti-competitively high compared to comparable geographic markets. In 1986, the State of Nevada had the highest per patient day billed charges in the United States and Humana-Sunrise had the highest per patient day billed charges in the State of Nevada; i.e., $1,617 per patient day. At all times relevant hereto, the percentage return on investment at Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a 37.44% return on investment. At all times relevant hereto, the profit margin of Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a profit margin of 36% compared to a national average of 14.4%.

42. In 1984, Humana, through its wholly-owned subsidiary, GROUP HEALTH, began to market and sell group health insurance policies in Clark County, Nevada. Aforesaid policies were sold through organized advertising activities in Clark County, Nevada, by means of newspaper advertisements, radio advertisements and television advertisements. GROUP HEALTH marketed and sold such policies

through its wholly-owned subsidiary Humana-Insurance using public advertising and private solicitation. In utilizing the above-described marketing scheme, Humana did so for the primary purpose of maintaining Humana's dominant market share of the gross charges from all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada by maintaining or increasing the number of patients utilizing Humana-Sunrise.

44. Humana and Humana-Insurance controlled the pricing mechanisms for the per diem charges for inpatient hospitalization and hospital services billed by Humana and for Humana group health policies. Humana and Humana-Insurance engaged in predatory pricing to give Humana an unlawful competitive advantage by allowing it to maintain, through revenues transmitted to its subsidiary by secret discounts, an anti-competitively high profit by maintaining or increasing the number of patients and in addition, by providing Humana-Insurance with a significantly lower per diem charge. As a result of aforesaid unlawful efforts to maintain or increase its market share and also as a result of aforesaid predatory pricing, Humana successfully and wilfully maintained its overwhelming percentage of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada.

45. The insurance agreement sold and marketed by Humana-Insurance through public advertising and private solicitation required its insureds to pay all expenses up to the designated deductible amount, and twenty percent (20%) of all expenses beyond the deductible; Humana-Insurance was required to pay the remaining eighty percent (80%) beyond the deductible.

46. Humana (Humana-Sunrise) and Humana-Insurance entered into a secret agreement in 1984 pursuant to which Humana-Insurance would pay Humana a discounted amount

for the portion of the per diem hospital charges for which it was responsible. No comparable discount was provided to other group health insurers. No comparable discount was provided on that portion of the charges paid by the insureds. Humana and Humana-Insurance agreed to keep this agreement secret from the Premium-Payor Class, the general public and state agencies.

47. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana-Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing or attempting to monopolize the provision of major for-profit acute care facilities in Clark County, Nevada.

48. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendant Humana and Humana-Insurance have developed a mutually supportive system to engage in specific unlawful acts and practices for the express purpose of maintaining anti-competitively high hospital profits in the provision of for-profit acute care hospital services in Clark County, Nevada or for the express purpose of establishing a dominant market share for the provision of Group Health Care Policy insurance, the latter which market share was used as a mechanism for maintaining or increasing the patients for acute hospital care services at Humana-Sunrise. Aforesaid specific unlawful acts and practices include, but are not limited to the following:

A. Promoting the use of Humana-Sunrise Hospital's services instead of other hospitals through Humana Care Plus insurance policies offered by Humana-Insurance by requiring extensive penalties for insureds who failed to use Humana-Sunrise Hospital. These penalties include, but are not limited to the following:

1. Requiring a different and punitive deductible for obtaining services from non-Humana for-profit acute care hospitals;

2. Requiring a different and punitive co-payment for obtaining services from non-Humana for-profit acute care hospitals;

3. Applying a different standard of review when evaluating and paying claims from non-Humana for-profit acute care hospitals. Humana-Insurance systematically denied certain items of non-Humana hospitalization claims prolonged the time of payment for non-Humana hospitalization claims and prolonged the appeal process time of non-Humana hospitalization claims.

B. Humana engaged in a pattern of predatory pricing by offering Humana-Insurance an unreasonable discount not extended to other group health care insurance entities in the Clark County, Nevada area and not extended to persons or entities paying co-payments. This unlawful behavior bestowed upon Humana an unlawful anti-competitive advantage by allowing it to collect co-payments from patients and non-Humana insurance group health insurers based on the purported per diem. At the same time, this unlawful behavior bestowed a further unlawful anti-competitive advantage upon Humana by allowing it to limit its purported profits by the discounted per diem extended to Humana-Insurance, thereby evading the ceiling upon Humana's profits which would have been imposed by cost-containment legislation. This unlawful behavior also bestowed an unlawful anti-competitive advantage upon Humana-Insurance by charging it less per diem than other group health insurers were charged by Humana;

C. Humana's wholly owned subsidiary Humana-Insurance offered premium rates for group health insurance policies that are anti-competitively high compared to premium rates in comparable geographic markets

because of the anti-competitively high charges for hospital services in Clark County, Nevada, compared to comparable geographic markets;

D. Humana's wholly-owned subsidiary Humana-Insurance offered premium rates for group health insurance policies above reasonable actuarial practices would have determined based on the predatory discounted per diem charge that it received but which was not extended to other group health insurers or co-payors;

E. While the premium rates for health insurance policies offered by Humana-Insurance were anti-competitively high compared to premium rates in comparable geographic markets, Humana-Insurance initially engaged in predatory pricing within the Clark County market itself by attempting to under-cut the charges by other group health insurers in the Clark County market. The express purpose of this initial predatory pricing was to obtain market share for the Humana group health policy. After successfully acquiring market share through the initial predatory pricing, Humana-Insurance then raised its premiums; and

F. Humana or Humana-Insurance provided predatory incentives to persons or entities selling Humana-Insurance group health care policies, including advance payments of compensation;

49. By means of the acts hereinabove described, Humana and Humana-Insurance have acquired or maintained or attempted to acquire and maintain a monopoly on for-profit acute care hospital services in Clark County, Nevada and Humana and Humana Health Insurance have attempted to acquire and preserve a dominant market share for the provision of Group Health Care Policy insurance in the Clark County, Nevada area, the latter which dominant market share was used as a mechanism for maintaining or increasing

the patients for acute hospital care services at Humana-Sunrise.

50. As a direct and proximate result of the anti-competitive actions hereinabove recited, and as intended by Defendant Humana and Humana-Insurance, the Anti-Trust Class has sustained damages in that it was required to pay anti-competitively high premiums for group health care policies in the Clark County geographic market compared to premiums charged for comparable group health policies in comparable geographic markets and in that it was required to pay anti-competitively high co-payments based on the anti-competitively high hospital charges billed by Humana.

51. Plaintiffs cannot now measure these damages with sufficient specificity to allege the dollar amount thereof, but estimates the damage to be in excess of $10,000,000.00, before trebling. When Plaintiffs have sufficient information which would enable them to allege their damages with more specificity, Plaintiffs will seek leave of the Court to amend their Complaint to insert said sum or, in the alternative, will prove such damages at trial.

52. The anti-competitive acts and practices of Humana and Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

53. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq., to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

THIRD CLAIM FOR RELIEF

(18 U.S.C. § 1961-1968)

54. Plaintiffs reassert and reallege each and every obligation contained in paragraphs 1 through 52 of the Amended Complaint as though fully set fourth at this point.

55. As part of a scheme to defraud Plaintiffs by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana-Insurance entered into a secret agreement (the "Agreement"). Pursuant to the Agreement, Humana-Insurance agreed to pay Sunrise Hospital a discounted amount for that portion of the hospital charges for which it was responsible. The portion of the charges paid by others, however, was not discounted but was still based on the usual and customary rate.

56. Premiums were not reduced by Humana-Insurance in the amount discounted. It was part of the scheme to defraud that Humana and Humana-Insurance used false and fraudulent pretenses, representations and promises calculated to deceive persons of ordinary prudence and due care and make material nondisclosures and concealment of fact and information important to the insureds (including but not limited to the existence of the secret agreement and the fact that Humana was billing Humana-Insurance at a different per diem) all so as to unlawfully, intentionally and wilfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed.R.Civ.Pro. Rule 23.

57. The scheme to defraud evolved over time a pattern of illegal activity that inflicted discreet harms on the insureds and others. The insureds, as victims of the unlawful patterns

of illegal activity, also suffered discreet losses as a result of these activities. The multifarious illegal activities through which the broad objectives of Humana and Humana-Insurance were carried out consisted of a complex pattern of individual transactions and group transactions. In carrying out the scheme to defraud, Defendants, Humana and Humana-Insurance engaged, *inter alia,* in conduct in violation of federal laws, to wit: 18 U.S.C. Section 1341; 18 U.S.C. Section 1343; and 18 U.S.C. § 664, as stated below:

(A) *18 U.S.C. Section 1341.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance, caused to be sent through the United States mail explanations of benefits, patient account statements, itemized statements, demand letters and other correspondence in order to collect co-payments from insureds for hospital charges as SUNRISE Hospital. Defendant Humana and/or Defendant Humana-Insurance, did not inform the insureds that Humana and Humana-Insurance had entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived in order to deceive the insured and obtain financial gain. This use of the United States mail in furtherance of the false and fraudulent scheme violates 18 U.S.C. Section 1341.

(B) *18 U.S.C. Sections 1343.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance, caused to be sent through radio and television transmissions, advertising promoting the Humana group health policy as part of the false and fraudulent scheme to defraud, Defendants further used the telephone lines to explain or discuss billing in order to collect co-payments from insureds for hospital charges at Sunrise

Hospital. Defendant Humana and/or Defendant Humana-Insurance, did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of fact and information to the insureds was intentionally and knowingly conceived in order to deceive the insured and obtain financial gain. This violates 18 U.S.C. Section 1343.

(C) *18 U.S.C. § 664.* As part of the false and fraudulent scheme the defraud, Defedant Humana and/or Defendant Humana-Insurance unlawfully and willfully converted co-payments and premiums to their own use. By failing to bill the co-payor class at a discounted rate, Humana converted these funds to its own use. By failing to pass along premium reductions, Humana-Insurance converted these funds to its own use. 18 U.S.C. § 664 explicitly provides that any person who "unlawfully and willfully abstracts or converts to his own use or to the use of another, any of the . . . premiums . . . of any employee welfare plan . . . ." shall be fined not more than $10,000, or imprisoned not more than five years, or both.

58. The Plaintiffs and the members of the designated class which they represent are each a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

59. Defendant Humana is a "person" within the meaning of 18 U.S.C. § 1963(3) and § 1964(c). Defendant Humana-Insurance is an "enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times. Defendant Humana was associated with an enterprise, that is, Humana-Insurance, and did conduct or participate directly or indirectly, in the

conduct of the affairs of Humana-Insurance through a pattern of activity within the meaning of 18 U.S.C. § 1961 (1)(B), 1961(5) and 1962(c), to-wit:

(a) Multiple instances of in violations of 18 U.S.C. § 1341;

(b) Multiple instances in violation of 18 U.S.C. § 1433; and

(c) Multiple instances of ERISA violations of 18 U.S.C. § 664.

60. Defendant Humana did use or invest, directly or indirectly, part of income derived, directly or indirectly, from a pattern of activity in the acquisition of any interest, income, or the establishment or operation of an enterprise, that is, Humana-Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of violations of 18 U.S.C. § 1341;

(b) Multiple instances of violations of 18 U.S.C. § 1433; and

(c) Multiple instances of ERISA violations of 18 U.S.C. § 664.

61. Humana and Humana-Insurance are an association in fact which constitute an "enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(a), which enterprise was engaged in and the activities which affected interstate commerce during the relevant times.

62. Defendant Humana did use or invest, directly or indirectly, income derived, directly or indirectly, from a pattern of unlawful activity in the acquisition of any interest in or the establishment or operation of an enterprise, that is, the association in fact comprised of Humana and Humana-

Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of mail fraud in violations of 18 U.S.C. § 1341;

(b) Multiple instances of wire fraud in violations of 18 U.S.C. § 1343; and

(c) Multiple instances of ERISA violations of 18 U.S.C. § 664.

63. By reason of the violations of 18 U.S.C. § 1962(c) § 1962(9) committed by Defendants Humana, the Plaintiffs and the members of the designated class which they represent were injured in an as yet undetermined amount, believed to be in excess of $10,000,000.00 within the meaning of 18 U.S.C § 1964(c) When Plaintiffs have sufficient information which would enable them to allege their damages with more specificty, Plaintiffs will seek leave of the Court to amend their Complaint to insert said sum or, in the alternative, will prove such damages at trial.

64. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq., to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $10,000,000.00 based upon the ERISA violations by Humana-Insurance on the First Claim for Relief.

2. A constructive trust be imposed in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. For declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana-Insurance to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. For general, special, and compensatory damages in an amount in excess of $10,000,000.00, before trebling, on the Second Claim for Relief.

5. For declaratory judgment and permanent injunction requiring Defendant to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. For general, special, and compensating damages in an amount in excess of $10,000,000.00 before trebbing, on the Third Claim for Relief.

7. For costs of suit and fees incurred herein.

8. For such further and other relief as the Court deems just and equitable.

DATED this 27th day of October, 1989.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.

/s/ Will Kemp
WILL KEMP, ESQ.

JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.

/s/ Will Kemp
WILL KEMP, ESQ.

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416 Gravier Street
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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

ERRATA SHEET FOR AMENDED COMPLAINT

TO THE HONORABLE COURT:

NOW APPEARS, Plaintiffs, Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc. d/b/a Best Glass Co., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, Waite, Schneider, Bayless & Chesley Co., L.P.A., and John L. Cummings III, Esq. and hereby informs the Court and Defendants that pp. 22 and 23 of the Amended Complaint filed on October 27, 1989, should be replaced by the attached pages. Replacement of pp. 22 and 23 are necessary to correct an inadvertent error.

DATED this 27th day of October, 1989.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.

JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF MAILING

I certify that on the 27th day of October, 1989, the Amended Complaint and Jury Demand was served upon Defendants by mailing a copy thereof, first class mail, postage prepaid, to:

Thomas H. Brock, Esq.
Burton J. Fishman, Esq.
Michael F. Moses, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., Suite 800
Washington, D.C. 20036

/s/ Wendi Perkins
An employee of JONES, JONES, CLOSE & BROWN, CHARTERED

RECEIPT OF COPY

RECEIPT of a true and correct copy of the within ERRATA SHEET FOR AMENDED COMPLAINT is hereby acknowledged on this 30 day of October, 1989.

LIONEL SAWYER & COLLINS

By: /stamp/ Paul R. Hejmanowski
PAUL R. HEJMANOWSKI, ESQ.
300 South Fourth Street
Suite 1700
Las Vegas, Nevada 89101

"enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times. Defendant Humana was associated with an enterprise, that is, Humana-Insurance, and did conduct or participate directly or indirectly, in the conduct of the affairs of Humana-Insurance through a pattern of activity within the meaning of 18 U.S.C. § 1961(1)(B), 1961(5) and 1962(c), to-wit:

(a) Multiple instances of in violations of 18 U.S.C. § 1341;

(b) Multiple instances in violation of 18 U.S.C. § 1433; and

(c) Multiple instances of violations of 18 U.S.C. § 664.

60. Defendant Humana did use or invest, directly or indirectly, part of income derived, directly or indirectly, from a pattern of activity in the acquisition of any interest, income, or the establishment or operation of an enterprise, that is, Humana-Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of violations of 18 U.S.C. § 1341;

(b) Multiple instances of violations of 18 U.S.C. § 1433; and

(c) Multiple instances of violations of 18 U.S.C. § 664.

61. Humana and Humana-Insurance are an association in fact which constitute an "enterprise" within the meaning of 18 U.S.C.

§ 1961(4) and § 1962(a), which enterprise was engaged in and the activities which affected interstate during the relevant times.

62. Defendant Humana did use or invest, directly or indirectly, income derived, directly or indirectly, from a pattern of unlawful activity in the acquisition of any interest in or the establishment or operation of an enterprise, that is, the association in fact comprised of Humana and Humana-Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of mail fraud in violations of 18 U.S.C. § 1341;

(b) Multiple instances of wire fraud in violations of 18 U.S.C. § 1343; and

(c) Multiple instances of violations of 18 U.S.C. § 664.

63. By reason of the violations of 18 U.S.C. § 1962(c) § 1962(9) committed by Defendants Humana, the Plaintiffs and the members of the designated class which they represent were injured in an as yet undetermined amount, believed to be in excess of $10,000,000.00 within the meaning of 18 U.S.C § 1964(c) When Plaintiffs have sufficient information which would enable them to allege their damages with more specificity, Plaintiffs will seek leave of the Court to amend their Complaint to insert said sum or, in the alternative, will prove such damages at trial.

64. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings

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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

NOTICE OF FILING AMENDED COMPLAINT

TO THE HONORABLE COURT:

NOW APPEARS, Plaintiffs, Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc. d/b/a Best Glass Co., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, Waite, Schneider, Bayless & Chesley Co., L.P.A., and John L. Cummings III, Esq. and hereby informs the Court and Defendants that Plaintiffs have amended their complaint.

In open Court and in the Court's September 27, 1989 ruling on Defendants' recent motion to dismiss, this Honorable Court granted Plaintiffs leave to amend their complaint. Specifically, the Court allowed Plaintiffs' the right to plead more definite claims to conform with the Court's instructions regarding the ERISA and Anti-Trust claims. See September 27, 1989 Order, pp. 12-13, 17. Plaintiffs have amended their ERISA and Anti-Trust claims and have also added a claim for violation of 18 U.S.C. § 1961-1968 (RICO) in order to disclose other alleged violations by Defendants of federal laws.

Rule 15(a) of the Federal Rules of Civil Procedure explicitly states that Plaintiffs may amend their complaint once "as a matter of course at any time before a responsive pleading is served." Fed.R.Civ.P. 15(a). Defendants have not yet filed a "responsive pleading". Accordingly, Plaintiffs inform the Court and Defendants that they have amended their Complaint.

DATED this 27th day of October, 1989.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
700 Valley Bank Plaza
300 So. Fourth Street
Las Vegas, NV 89101-6026

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the within AMENDED COMPLAINT is hereby acknowledged on this 27 day of October, 1989.

LIONEL SAWYER & COLLINS

By: /stamp/ Paul R. Hejmanowski
PAUL R. HEJMANOWSKI, ESQ.
300 South Fourth Street
Suite 1700
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 27th day of October, 1989, the Notice of Filing Amended Complaint was served upon Defendants by mailing a copy thereof, first class mail, postage prepaid to:

Thomas H. Brock, Esq.
Burton J. Fishman, Esq.
Michael F. Moses, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., Suite 800
Washington, D.C. 20036

/s/ Janet A. Slone
An employee of JONES, JONES,
CLOSE & BROWN, CHARTERED

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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through X, inclusive,

Defendants.

SECOND AMENDED COMPLAINT AND JURY DEMAND

COME NOW, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, J. Randall Jones and Will Kemp of Jones, Jones, Close & Brown, Chartered; Stanley M. Chesley of Waite, Schneider, Bayless & Chesley Co., L.P.A.; John L. Cummings III of Cummings, Cummings & Dudenhefer; and Wendell Gauthier of Gauthier & Murphy, and for their causes of action against Defendants complain, aver and allege as follows:

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, *et seq.*, the Employment Retirement Income Security Act ("ERISA") these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc., under Section 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. §§ 1961 - 1968. Subject matter jurisdiction is conferred upon this Court by 29 U.S.C. § 1132, 15 U.S.C. §§ 15 & 16, and 28 U.S.C. § 1337.

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 28 U.S.C. § 1391 and 29 U.S.C. § 1132.

3. Defendants above named maintain an office and transact business and may be found within the District of Nevada. The interstate trade and commerce involved and affected by the alleged violations of the antitrust laws is carried on, in part, within the District of Nevada.

PARTIES

4. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant, Humana Health Insurance of Nevada, Inc., ("Humana-Insurance") through payroll deductions.

5. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana-Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Marrietta Cade was at all times relevant Humana-Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana-Insurance policy. Robert Cade was hospitalized at Humana Hospital Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

6. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and did make premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through

November 9, 1986. Ms. Andrews, under the 20% co-payment provisions, was obligated to pay and did pay a portion of all of her hospitalization costs.

7. Plaintiff Mary Lou Buehler, 210 Myers Avenue, Henderson, Nevada 89015, has been insured with Humana-Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in, October of 1988 Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her billings for those hospitalizations were $23,293.94 and $2,736.85, respectively. Under the co-payment provision of her policy, she was obligated to pay 20% of the costs of her hospitalization. Ms. Buehler has paid a portion of the co-payment.

8. Plaintiff Helen Staves, HCR 65, Box 71408, Pahrump, Nevada 89041, has been insured with Humana-Insurance since July 1988. At all times relevant, Mrs. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana-Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital Sunrise. Pursuant to the co-payment provisions under her policy, she is required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Mrs. Staves paid her portion of the co-payment.

9. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana-Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987, Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana-Insurance. On February

12, 1988, Mr. Bratton was admitted to Humana Hospital Sunrise. At that time day surgery was performed and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

10. None of the individual Plaintiffs above-named were ever informed that Humana-Insurance was able to negotiate favorable hospitalization rates at Humana Hospital Sunrise or that Humana-Insurance negotiated such rates for itself.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. (''Best Glass''), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has utilized Humana-Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass' group number with Humana-Insurance is 82801-18351-001. When Best Glass first became an insured with Humana-Insurance, the rates were very reasonable, $64.23 per employee per billing period. In 1986 this rate increased by 3% and in 1987 the rate jumped 13%. Finally, in 1988, when Best Glass decided not to renew with Humana-Insurance, Humana-Insurance sought a premium increase of 41% to continue coverage of employees of Best Glass. At no time did Humana-Insurance ever inform Best Glass that it was able to negotiate favorable hospitalization rates for its employees using Humana Hospital Sunrise for hospitalizations or that Humana-Insurance negotiated such rates for itself.

12. Defendant Humana Health Insurance of Nevada, Inc. (''Humana-Insurance'') is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana-Insurance is wholly owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. (''Group Health'') Humana-Insurance markets and sells group health insurance through employee benefit plans to employees

throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona and Utah.

13. Defendant Humana, Inc. (''Humana'') is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has for many years, been one of the largest owners and operators of acute care hospitals in the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana-Sunrise Hospital in Las Vegas, Nevada. Although Humana-Sunrise Hospital was only one of Humana's 87 hospitals in 1986, according to Humana's report to its stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana Resources in 1986, Humana-Sunrise generated thirty eight percent (38%) of Humana's pretax profits.

14. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOE CORPORATIONS I through V, inclusive, are unknown to Plaintiffs at this time, who therefore sue said Defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each of said Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will seek leave to amend this Complaint to allege their true names and capacities when and as ascertained.

CLASS ACTION

15. By order of this Court on September 26, 1989 Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade,

Mary Lou Buehler and Helen Staves (the "Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. Pro. 23(b)(3).

16. By order of this court on September 26, 1989, Plaintiff Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves and Searle Auto Glass, Inc. (the "Anti-Trust Class") were recognized as class representatives pursuant to Fed. R. Civ. Pro. 23(b)(3). This Anti-Trust Class consists of individuals or entities paying at least a portion of the Humana-Insurance premiums during the relevant times.

17. By order of this Court on July 10, 1991, Plaintiffs Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, and Randolph Bratton (the "RICO Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3).

18. By order of this Court on July 10, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Searle Auto Glass, Inc. (the "RICO Premium-Payor Class" were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3).

CLASS ACTION

FIRST CLAIM FOR RELIEF

(Breach of ERISA Fiduciary Duties;
Engaging in Prohibited Transactions;
and Retaining Excessive Compensation)

19. The Co-Payor class reasserts and realleges each and every allegation contained in paragraphs 1 through 18 of the Complaint as though fully set forth at this point.

20. The Co-Payor Class consists of employees obtaining health insurance benefits under the employee benefit plan as defined under 29 U.S.C. 1001 *et seq.*

21. The members of the Co-Payor Class incurred charges at Humana Hospital Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana-Insurance is the insurer of the members of the Co-Payor Class through its insurance plan, Humana Care Plus.

22. The Humana Care Plus policy required that each member of the Co-Payor Class pay 20% of hospital costs. Humana-Insurance agreed to pay the remaining 80% of the hospital charges. The Co-Payor Class believed, and their agreement with Humana-Insurance provided, that the members of the Co-Payor Class and Humana-Insurance would be paying their respective contractual percentage of the charges.

23. Humana and Humana-Insurance negotiated a secret agreement which greatly reduced or discounted hospital charges for Humana-Insurance patients incurring charges at Humana Hospital Sunrise which constitutes discretionary authority and discretionary control respecting management of the plan, discretionary authority and discretionary control respecting management or disposition of its assets, or discretionary authority or discretionary responsibility in the administration of the plan. Humana-Insurance is a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

24. The agreement Humana-Insurance negotiated with Humana specifically provided for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate.

25. Humana-Insurance exercised discretionary authority during the aforementioned negotiations with Humana. The reduced or discounted hospital charges were a crucial part of the administration of the health care plan.

26. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced co-payments. 29 U.S.C. § 1004.

27. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to refund the discount of the reduced costs it was able to negotiate with Humana. 29 U.S.C. § 1104.

28. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by breaching its duty to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana-Insurance imprudently decided to retain the co-payment refunds it negotiated with Humana. Humana-Insurance received excessive compensation in violation of its fiduciary duties. 29 U.S.C. § 1104.

29. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including but not limited to, AB 289. 29 U.S.C. § 1104.

30. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by dealing with the assets of the plan in its own interest or for its own account. 29 U.S.C. § 1106.

31. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by acting on behalf of Humana whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana-Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana. 29 U.S.C. § 1106.

32. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by unlawfully receiving consideration for its own personal account in connection with a transaction involving the assets of the plan. 29 U.S.C. § 1106.

33. It would be wrongful for Humana-Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of Humana-Insurance's duties to the Co-Payor Class and agreement with the Co-Payor Class.

34. A constructive trust should be imposed on the Defendants which requires turnover of all monies obtained through the scheme described herein.

35. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

36. As a result of the Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit upon Defendant Humana-Insurance. Defendant Humana-Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana-Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of the scheme, the Defendant Humana-Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

37. The acts and practices of Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana-Insurance.

38. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana-Insurance,

and it is estimated that the approximate actual damages are in excess of $84,520,143.00.

39. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

SECOND CLAIM FOR RELIEF

(Anti-Trust)

40. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 39 of the Complaint as though fully set forth at this point.

41. This Premium-Payor class consists of individuals or entities paying all or a portion of the Humana-Insurance premiums during the period 1985 to 1988, including but not limited to employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

42. Defendant Humana is in the business of owning and operating for-profit acute care health facilities. Humana owns and operates a for-profit acute care health facility named Humana-Sunrise Hospital which provides a full range of hospital services within Clark County, Nevada. Approximately sixty percent (60%) of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada were billed by Humana-Sunrise Hospital in the relevant time period. This percentage is, and at all times relevant hereto has been, the largest market share of any for profit acute care facility in Clark County, Nevada.

43. At all times relevant hereto, the hospital charges billed by Humana for hospitalization at Humana-Sunrise were anti-competitively high compared to comparable geographic markets. In 1986, the State of Nevada had the highest per patient day billed charges in the United States and Humana-Sunrise had the highest per patient day billed charges in the State of Nevada; i.e., $1,617 per patient day. At all times relevant hereto, the percentage return on investment at Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a 37.44% return on investment. At all times relevant hereto, the profit margin of Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a profit margin of 36% compared to a national average of 14.4%.

44. In 1984, Humana, through its wholly-owned subsidiary, GROUP HEALTH, began to market and sell group health insurance policies in Clark County, Nevada. Aforesaid policies were sold through organized advertising activities in Clark County, Nevada, by means of newspaper advertisements, radio advertisements and television advertisements. GROUP HEALTH marketed and sold such policies through its wholly-owned subsidiary Humana-Insurance using public advertising and private solicitation. In utilizing the above-described marketing scheme, Humana did so for the primary purpose of maintaining Humana's dominant market share of the gross charges from all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada by maintaining or increasing the number of patients utilizing Humana-Sunrise.

45. Humana and Humana-Insurance controlled the pricing mechanisms for the per diem charges for impatient hospitalization and hospital services billed by Humana and for Humana group health policies. Humana and Humana-Insur-

ance engaged in predatory pricing to give Humana an unlawful competitive advantage by allowing it to maintain, through revenues transmitted to its subsidiary by secret discounts, an anti-competitively high profit by maintaining or increasing the number of patients and in addition, by providing Humana-Insurance with a significantly lower per diem charge. As a result of aforesaid unlawful efforts to maintain or increase its market share and also as a result of aforesaid predatory pricing, Humana successfully and wilfully maintained its overwhelming percentage of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada.

46. The insurance agreement sold and marketed by Humana-Insurance through public advertising and private solicitation required its insureds to pay all expenses up to the designated deductible amount, and twenty percent (20%) of all expenses beyond the deductible; Humana-Insurance was required to pay the remaining eighty percent (80%) beyond the deductible.

47. Humana (Humana-Sunrise) and Humana-Insurance entered into a secret agreement in 1984 pursuant to which Humana-Insurance would pay Humana a discounted amount for the portion of the per diem hospital charges for which it was responsible. No comparable discount was provided to other group health insurers. No comparable discount was provided on that portion of the charges paid by the insureds. Humana and Humana-Insurance agreed to keep this agreement secret from the Premium-Payor Class, the general public and state agencies.

48. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana-Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing or attempting to monopolize the provision of major for-profit acute care facilities in Clark County, Nevada.

49. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendant Humana and Humana-Insurance have developed a mutually supportive system to engage in specific unlawful acts and practices for the express purpose of maintaining anti-competitively high hospital profits in the provision of for-profit acute care hospital services in Clark County, Nevada or for the express purpose of establishing a dominant market share for the provision of Group Health Care Policy insurance, the latter which market share was used as a mechanism for maintaining or increasing the patients for acute hospital care services at Humana-Sunrise. Aforesaid specific unlawful acts and practices include, but are not limited to the following:

A. Promoting the use of Humana-Sunrise Hospital's services instead of other hospitals through Humana Care Plus insurance policies offered by Humana-Insurance by requiring extensive penalties for insureds who failed to use Humana-Sunrise Hospital. These penalties include, but are not limited to the following:

1. Requiring a different and punitive deductible for obtaining services from non-Humana for-profit acute care hospitals;

2. Requiring a different and punitive co-payment for obtaining services from non-Humana for-profit acute care hospitals;

3. Applying a different standard of review when evaluating and paying claims from non-Humana for-profit acute care hospitals. Humana-Insurance systematically denied certain items of non-Humana hospitalization claims prolonged the time of payment for non-Humana hospitalization claims and prolonged the appeal process time of non-Humana hospitalization claims.

B. Humana engaged in a pattern of predatory pricing by offering Humana-Insurance an unreasonable discount not extended to other group health care insurance entities in the Clark County, Nevada area and not extended to persons or entities paying co-payments. This unlawful behavior bestowed upon Humana an unlawful anti-competitive advantage by allowing it to collect co-payments from patients and non-Humana insurance group health insurers based on the purported per diem. At the same time, this unlawful behavior bestowed a further unlawful anti-competitive advantage upon Humana by allowing it to limit its purported profits by the discounted per diem extended to Humana-Insurance, thereby evading the ceiling upon Humana's profits which would have been imposed by cost-containment legislation. This unlawful behavior also bestowed an unlawful anti-competitive advantage upon Humana-Insurance by charging it less per diem than other group health insurers were charged by Humana;

C. Humana's wholly owned subsidiary Humana-Insurance offered premium rates for group health insurance policies that are anti-competitively high compared to premium rates in comparable geographic markets because of the anti-competitively high charges for hospital services in Clark County, Nevada, compared to comparable geographic markets;

D. Humana's wholly-owned subsidiary Humana-Insurance offered premium rates for group health insurance policies above reasonable actuarial practices would have determined based an the predatory discounted per diem charge that it received but which was not extended to other group health insurers or co-payors; and

E. While the premium rates for health insurance policies offered by Humana-Insurance were anti-competitively high compared to premium rates in comparable geographic markets, Humana-Insurance initially engaged in predatory pricing within the Clark County market itself by attempting to under-cut the charges by other group health insurers in the Clark County market. The express purpose of this initial predatory pricing was to obtain market share for the Humana group health policy. After successfully acquiring market share through the initial predatory pricing, Humana-Insurance then raised its premiums.

50. By means of the acts hereinabove described, Humana and Humana-Insurance have acquired or maintained or attempted to acquire and maintain a monopoly on for-profit acute care hospital services in Clark County, Nevada and Humana and Humana Health Insurance have attempted to acquire and preserve a dominant market share for the provision of Group Health Care Policy insurance in the Clark County, Nevada area, the latter which dominant market share was used as a mechanism for maintaining or increasing the patients for acute hospital care services at Humana-Sunrise.

51. As a direct and proximate result of the anti-competitive actions hereinabove recited, and as intended by Defendant Humana and Humana-Insurance, the Anti-Trust Class has sustained damages in that it was required to pay anti-competitively high premiums for group health care policies in the Clark County geographic market compared to premiums charged for comparable group health policies in comparable geographic markets and in that it was required to pay anti-competitively high co-payments based on the anti-competitively high hospital charges billed by Humana.

52. It is estimated that the approximate actual damages of the Anti-Trust Class are in excess of $181,034,570.00, the principal of which is subject to trebling.

53. The anti-competitive acts and practices of Humana and Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

54. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

THIRD CLAIM FOR RELIEF

(18 U.S.C. §§ 1961-1968)

55. Plaintiffs reassert and reallege each and every obligation contained in paragraphs 1 through 54 of the Amended Complaint as though fully set fourth at this point.

56. As part of a scheme to defraud Plaintiffs by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana-Insurance entered into a secret agreement (the "Agreement"). Pursuant to the Agreement, Humana-Insurance agreed to pay Sunrise Hospital a discounted amount for that portion of the hospital charges for which it was responsible. The portion of the charges paid by others, however, was not discounted but was still based on the usual and customary rate.

57. Premiums were not reduced by Humana-Insurance in the amount discounted. It was part of the scheme to defraud that Humana and Humana-Insurance used false and fraudulent pretenses, representations and promises calculated to deceive persons of ordinary prudence and due care and make material nondisclosures and concealment of fact and information important to the insureds (including but not limited

to the existence of the secret agreement and the fact that Humana was billing Humana-Insurance at a different per diem) all so as to unlawfully, intentionally and wilfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed.R.Civ-Pro. Rule 23.

58. The scheme to defraud evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which the broad objectives of Humana and Humana-Insurance were carried out consisted of a complex pattern of individual transactions and group transactions. In carrying out the scheme to defraud, Defendants, Humana and Humana-Insurance engaged, *inter alia,* in conduct in violation of federal laws, to wit: 18 U.S.C. Section 1341 and 18 U.S.C. Section 1343, as stated below:

(A) *18 U.S.C. Section 1341.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance, caused to be sent through the United States mail explanations of benefits, patient account statements, itemized statements, demand letters and other correspondence in order to collect co-payments from insureds for hospital charges as Sunrise Hospital. Defendant Humana and/or Defendant Humana-Insurance, did not inform the insureds that Humana and Humana-Insurance had entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally

and knowingly conceived in order to deceive the insured and obtain financial gain. This use of the United States mail in furtherance of the false and fraudulent scheme violates 18 U.S.C. Section 1341.

(B) *18 U.S.C. Section 1343.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance transmitted or caused to be transmitted in interstate commerce wire, radio, and television transmissions, including without limitation the following:

(1) Defendants sent, or caused to be sent, through interstate radio and television transmissions, advertisements promoting the Humana group health policy. Those radio and television transmissions were broadcast from locations in Nevada across state borders to persons located in Arizona and/or Utah. In those transmissions Defendant Humana and/or Defendant Humana-Insurance did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived in order to deceive the insureds and obtain financial gain.

(2) Defendants used the interstate telephone lines to explain or discuss billings in order to collect co-payments from insureds for hospital charges incurred at Sunrise Hospital. Defendants maintained offices both in Las Vegas, Nevada and in Louisville, Kentucky. Defendants engaged in telephone conversations from their Nevada offices with Plaintiffs located in other states, including without limitation Arizona, California,

and Utah, and from their Kentucky offices with Plaintiffs located in other states, including without limitation Arizona, California, Nevada, and Utah. In those telephone conversations Defendant Humana and/or Defendant Humana-Insurance did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived by Defendants in order to deceive the insureds and obtain financial gain.

(3) On or about December 1, 1987, Defendants established a Louisville Claims Center in Louisville, Kentucky and a toll-free telephone line to that office for the specific purpose of handling claims from corporate Plaintiffs located in Nevada (Exhibit A). Defendants engaged in telephone conversations from their Kentucky offices with corporate Plaintiffs located in Nevada. In those conversations Defendant Humana and/or Defendant Humana-Insurance did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived by Defendants in order to deceive the insureds and obtain financial gain.

(4) Defendants engaged in telephone conversations from their offices in Louisville, Kentucky with persons in Nevada in the offices of the government of the State of Nevada for the purpose of executing Defendants' scheme to defraud. For example, on May 2, 1989, John

Andris, in-house counsel for Defendants, placed a telephone call to Herschell Dunham of the Nevada Insurance Division, concerning the merger of Humana-Insurance with Humana, Inc. and documents requested by the Insurance Division relating to the Division's examination of Humana-Insurance (Exhibit B). These telephone conversations were in support of the scheme to defraud.

(5) Plaintiffs are informed and believe and thereupon allege that Humana, Inc. and/or Humana-Insurance transferred millions of dollars by wire transfer from Nevada to other states and from other states to Nevada for the purpose of executing Defendants scheme to defraud. For example, on or about March 2, 1984, Humana, Inc. ordered $1,501,355,63 transferred by wire from Louisville, Kentucky to First Interstate Bank in Reno, Nevada for the purchase of a Treasury Bill to be held at the bank in an account maintained in the name of Humana-Insurance (Exhibit C). This interstate transfer of funds was in support of the scheme to defraud.

This use of interstate wire transmissions in furtherance of the false and fraudulent scheme violates 18 U.S.C. § 1343.

59. The Plaintiffs and the members of the designated class which they represent are each a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

60. Defendant Humana is a "person" within the meaning of 18 U.S.C. § 1963(3) and § 1964(c). Defendant Humana-Insurance is an "enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times. Defendant Humana was associated with an enterprise, that is, Humana-Insurance, and did conduct or participate directly or indirectly, in the

conduct of the affairs of Humana-Insurance through a pattern of activity within the meaning of 18 U.S.C. §§ 1961 (1)(B), 1961(5) and 1962(c), to-wit:

(a) Multiple instances of violations of 18 U.S.C. § 1341;

(b) Multiple instances of violations of 18 U.S.C. § 1343.

61. Humana and Humana-Insurance are an association-in-fact that constitutes an "enterprise" within the meaning of 19 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times.

62. By reason of the violations of 18 U.S.C. § 1962(c) committed by Defendants Humana, it is estimated that the approximate actual damages of the RICO class are in excess of $181,034,570.00, the principal of which is subject to trebling.

63. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $84,520,143.00 based upon the ERISA violations by Humana-Insurance on the First Claim for Relief.

2. A constructive trust be imposed in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. For declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana-Insurance to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. For general, special, and compensatory damages in an amount in excess of $181,034,570.00, on the Second Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

5. For declaratory judgment and permanent injunction requiring Defendant to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. For general, special, compensating damages in an amount in excess of $181,034,570.00 on the Third Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

7. For costs of suit and fees incurred herein.

8. For such further and other relief as the Court deems just and equitable.

DATED this 12th day of August, 1991.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Las Vegas, Nevada 89101

WAITE, SCHNEIDER, BAYLESS
& CHESLEY CO., L.P.A.

By /s/ J. Randall Jones /for
STANLEY M. CHESLEY, ESQ.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, Ohio 45202

CUMMINGS, CUMMINGS & DUDENHEFER

By /s/ J. Randall Jones /for
JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

GAUTHIER & MURPHY

By /s/ J. Randall Jones /for
WENDELL GAUTHIER, ESQ.
3500 North Hullen Street
Metairie, LA 70002

ATTORNEY FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Suite 700
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 12th day of August, 1991, the foregoing Second Amended Complaint and Jury Demand was served on the parties by mailing a copy thereof, first class mail, postage prepaid, to:

Louis E. Garfinkel, Esq.
LIONEL SAWYER & COLLINS
300 South Fourth Street
Suite 1600
Las Vegas, Nevada 89101

Mark J. Biros, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., #800
Washington, D.C. 10036

/s/ Janet L. Slone
An employee of JONES, JONES,
CLOSE & BROWN, CHARTERED

[Letterhead of Humana Health Care Plans, Las Vegas, Nevada]

November 13, 1987

Mr. Robert Evans
Supervisor Life and Health
Department of Commerce
Insurance Division
201 South Fall Street
Carson City, Nevada 89710

Re: Transfer of claims processing and payment from Mutual Administrators, Inc. to Humana Corporate Claims System, Louisville, Kentucky.

Dear Bob,

The primary purpose for the above transfer is to better serve the consumer by providing them the claims, utilization, and trend reports on a regular basis. By providing these reports, it will enable the consumer to better manage health care costs and provide a review of when employees and dependents are using health care services. These kinds of reports currently are not able to be generated on a regular basis through Mutual Administrators, Inc. Also, this will enable Humana Health Insurance of Nevada, Inc. to better comply with the recent proposed Legislation in reporting data on health costs to the Department. The following is an outline of notification and implementation:

1. Notification:
   (a) Effective data of termination of contract is December 1, 1987.
   (b) Mutual Administrators, Inc. will be notified in person with letter on November 19, 1987.
   (c) All accounts will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

(d) All brokers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

(e) All providers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

(f) Legal council has approved termination.

2. Responsibilities:

(a) Mutual Administrators, Inc.

(1) Through November 30, 1987, Mutual Administrators, Inc. will be responsible for all claims incurred and reported.*

(2) Mutual Administrators, Inc. will be responsible for the runout.*

(b) Humana Health Insurance of Nevada, Inc.

(1) Currently Humana, in Las Vegas, has five customer service representatives, four trained and one to be trained by December 1, 1987.

(2) Currently ten terminals with inquiry capabilities with wiring and equipment for an additional twelve stations, if necessary.

(3) Additional personnel to be added as needed.

(4) Twenty-four hour hot line service to Las Vegas office.

(5) Seventeen lines available for consumer inquiries.

(6) Additional 2400 square foot in current building for expansion.

(7) An 800 number to Las Vegas office for customer service outside of Clark County.

(8) Account will be set up at FIB in Nevada for claims payments.

(c) Humana Corporate Claims - Louisville, Kentucky:

* If Mutual Administrators, Inc. refuses to accomodate, Humana is prepared to assume the responsibility.

(1) Adjudicate and pay claims for Nevada.

(2) Produce cards - cards have been ordered (temporary cards for December 1, 1987 and new permanent cards by January 1, 1988.

(3) Plans loaded and tested successfully in Corporate system for implementation December 1, 1987 or earlier if necessary.

(4) An 800 number to Corporate customer service in addition to local customer service lines.

(5) Provide regular reports (see attached).

(6) Two Corporate claims managers will be in Las Vegas the week of November 9, 1987 for claims instruction and coordination.

b, if any other information is needed, please give me a call.

Sincerely,

/s/ John R. Egermayer
John R. Egermayer
Executive Director

JRE:dw

cc: Roger Collins
Larry Cash
Judy Zelinski
Joyce Anderson
Bruce McClure
Jerry McClellan
Joe Lawrence

[Message Form—Tops Form 3002P]

IMPORTANT MESSAGE

FOR Herschell

DATE 5-2 TIME 11:20 A.M.

M John Andris

OF Humana (law Dept)

PHONE 502-580-3717

TELEPHONED ✓ PLEASE CALL ✓

MESSAGE Merger &
documents you
asked for regarding
exam

SIGNED SKK

[Letterhead of First Interstate Bank, Reno, Nevada]

March 9, 1984

Mr. David Reinhardt
Investment Management Department
Humana, Inc.
P. O. Box 1438
Louisville, Kentucky 40201

Dear Mr. Reinhardt:

Enclosed is the confirmation statement for the Treasury Bill purchased on March 2, 1984. Although the statement shows principal of $1,501,300.00, please let this letter confirm receipt from you for $1,501,355.63 by wire on March 2.

For your information, we have reserved a corporate demand account number 002-0011288 for Humana Health Insurance of Nevada, Inc. To complete required documentation, kindly fill in the items checked on the enclosed signature cards/ corporate resolution form and the taxpayer identification form, and return these at your earliest convenience.

We appreciate your selecting First Interstate Bank of Nevada, N.A. for your banking needs.

Sincerely,

/s/ Marvin M. Mann

MMM:aa

Enclosures

[Form AC-250T (0983), First Interstate Bank, Reno, NV]

Confirmation and Statement

Order No. 0011—T

We confirm according to the transaction code below and the terms stated hereon and the reverse side hereof. If this confirmation is not in all respects in accordance with your understanding, please notify us immediately.

Account Number (BLANK) Trade Date 3-1-84
Settlement Date 3-2-84 Security Number/Cusip (BLANK)

Humana Health Insurance
of Nevada, Inc.
C/O Marvin Mann

PRINCIPAL $1,501,350.00

TOTAL AMOUNT DUE $1,501,350.00

Transaction X Sold Type I Tran Code 2
Trader/Salesman 2 Price 95,3238 Rate 9.30 Disc

Par Value $1,575,000.00 Yield 9.89

Description U.S. Treasury Bills Due 8-30-84

Payment and Delivery Instructions: Hold in Safekeeping

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

Case No. CV-S-89-249-PMP

MARY FORSYTH, et al.

Plaintiffs,

vs.

HUMANA, INC., et al.

Defendants.

STATE OF OHIO)
) SS:
COUNTY OF HAMILTON)

AFFIDAVIT OF BARON T. YOUN

I, Baron T. Youn, being duly sworn, depose and state as follows:

1. I am a computer data consultant retained by Plaintiffs' counsel to examine the data submitted by Humana Inc. (Humana) as well as the assumptions upon which the damage calculations were based. The set of data files I reviewed was to be the exact same set that Humana used to calculate their financial compensation liability in this case. I have also reviewed the deposition and affidavit testimony of Bruce McClure and Joseph Shutts.

2. The data I was instructed to review was supplied on magnetic tape and supplied in the EBCIDIC format. This data was actually a series of reports that were run and the output data was directed to a data file instead of being directed to a printer. This re-direction to a data file was necessary because the reports contain over 220,000 transactions. The EBCIDIC encoded data on the magnetic tape was converted to ASCII format and transferred to media that is capable of being read on an IBM PC compatible personal

computer. This conversion process uses was performed by the Shafstall Corp. located in Indianapolis, Indiana and specialists in data format conversion. The conversion does not alter any values of the data, only the format.

3. Upon careful study and review of the data submitted by Humana, I have found several errors in their calculations. For example, on page one of the report labeled "HUMANA DIFFERENCE FOR NEVADA MEMBERS, DETAIL REPORT FOR THE CALENDAR YEAR ENDING ON 12/31/85", I have found two separate transactions that are in error out of the twelve transactions listed on that page. If this error rate is multiplied across the 220,000 plus transactions, any calculations using this data set will be flawed. Since this data set is alleged to be the same data set Humana used to figure their liability, their resultant sum they arrived at using this data set must be disregarded because of the errors contained in the original data set.

I declare under penalty of perjury that the forgoing is true and correct to the best of my knowledge, information and belief.

/s/ Baron T. Youn
Baron T. Youn

Subscribed and sworn to before me by Baron T. Youn this 17th day of February, 1994, to be his free act and deed.

My Commission expires:
July 30, 1997

/s/ Amy L. Kindell
Notary of Public

[stamp—AMY L. KINDELL/Notary Public, State of Ohio/
My Commission Expires July 30, 1997]

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE No. CV-S-89-249 PMP (LRL)

MARIETTA CADE, *et al.*,

Plaintiffs

v.

HUMANA INC., *et al.*,

Defendants

COMMONWEALTH OF KENTUCKY)
) ss:
COUNTY OF JEFFERSON)

AFFIDAVIT OF BRUCE K. McCLURE

I, Bruce K. McClure, being duly sworn, depose and state as follows:

1. I am employed by Humana Inc. ("Humana") as Director of Claims - Finance and Administration.

2. I have been employed by Humana since March, 1983.

3. I am responsible for directing and managing Humana's claims processing systems for Humana's health insurance and health maintenance organization subsidiaries including Humana Health Insurance of Nevada, Inc. ("Humana Insurance").

4. I supervised an analysis of all claims submitted by persons insured by Humana Insurance during 1984-1988, inclusive, who had a coinsurance obligation to Humana Hospital-Sunrise under their health insurance policies. Part of the purpose of this analysis was to identify for each year in question the total dollar difference between the insureds'

coinsurance obligations when their coinsurance was calculated on the basis of the hospital's charges versus the discounted amount of the hospital's charges. In order to determine the difference in the coinsurance obligations, I reviewed pages 18-21 of the July 21, 1993 Memorandum Decision and Order (the "Order") of the Court in this matter and applied the formula set out in the Order to the claims described above. The total amount of out-of-pocket obligations of these insureds in excess of what they would have owed if their coinsurance was on the discounted amount (taking into effect in each case their personal expense limitation) for the years 1984-1988 was $1,623,312. The table below sets out the amount for each year in question:

Year	Reduction in Co-Insurance Obligation If Co-Insurance Based on Discounted Amount
1984	$ 24,103
1985	420,658
1986	604,948
1987	410,033
1988	163,570
TOTAL	$1,623,312

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

/s/ Bruce K. McClure
Bruce K. McClure

Subscribed and sworn to before me by Bruce K. McClure this 9th day of November, 1993, to be his free act and deed.

My Commission expires: September 20, 1997

/s/ [*signature illegible*]
NOTARY PUBLIC,
STATE AT LARGE

AFFIDAVIT OF EDWARD CUPIT, CPA

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

EDWARD CUPIT, being first duly sworn, deposes and says:

1. I, Edward Cupit, am a certified public accountant, duly authorized to practice in the state of Nevada.

2. I am a partner in the accounting firm of Cupit, Milligan & Ogden, which firm is located at 1695 Meadow Wood Lane, Suite 100, Reno, Nevada 89502.

3. This affidavit is offered on behalf of Plaintiffs in the matter of *Forsyth v. Humana,* CV-S-89-249-PMP (LRL), in reference to Plaintiffs' Motion for Reconsideration.

4. I have examined records indicating the discounts that Humana Hospital granted to numerous insurance companies and self-insured employers (together "insurers") during the period from 1986 through 1988. In my professional opinion, calculating the difference between the average of those discounts and the discounts that Humana Hospital granted Humana Insurance during the same period represents a reasonable alternative method of determining the "profit" that Humana Insurance derived as a direct consequence of its discount arrangement with Humana Hospital.

5. I have calculated that amount as follows:

a. During the year ended August, 1986, Humana Hospital's average discount to all insurers other than Humana Insurance was 38.2%. During the year ended August, 1987, that average discount was 44.9%. During the year ended August, 1988, that average discount was 44.7%. I do not have records indicating the average discounts before the year ended August, 1986, or after the year ended August, 1988.

b. During the years ended in August, 1986, August, 1987, and August, 1988, the discount that Humana Hospital granted to Humana Insurance was 89.1% The difference between that discount and the average discount that Humana Hospital granted to other insurers during those years (43.4%), was 45.7% Humana Hospital transferred $44,382,000 to Humana Insurance in the form of discounts for this period. Applying 45.7% to those discounts yields a total of $20,282,574.

d. The total of $20,282,574 represents a reasonable calculation of the "profit" that Humana Insurance derived as a direct consequence of its discount arrangement with Humana Hospital during the years indicated, not including interest.

DATED this 10th day of November, 1993.

/s/ Edward Cupit
EDWARD CUPIT

State of California)
County of _____)

On Nov. 10, 1993 before me, Amy Jordan personally appeared Edward Cupit personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature /s/ Amy Jordan

[stamp—OFFICIAL SEAL/AMY JORDAN/NOTARY PUBLIC--
CALIFORNIA/Principal Office in MARIN County/
My Commission Expires July 18, 1994]

SUPPLEMENTAL REPORT OF EDWARD CUPIT

I. Materials Reviewed:

1. Plaintiffs' Complaint filed 3/29/85
2. Plaintiffs' Amended Complaint filed 10/27/89
3. Plaintiffs' Second Amended Complaint filed 8/12/91
4. Order of the Honorable Philip M. Pro, dated July 8, 1991
5. Nevada Quarterly financial statements of Sunrise Hospital for the years 1985 - 1989
6. Quarterly financial statements of Humana Insurance for the years 1985 - 1988 to the Nevada Department of Insurance
7. Annual statements for Humana Insurance filed with the Nevada Insurance Department for the years 1985 - 1988
8. Annual Published Financial Statements for 1985 - 1988
9. Humana, Inc. Medicare Home Office Reports from Blue Cross of Kentucky and Aetna
10. 10/14/86 Report of Examination prepared by Insurance Division of Humana Health Insurance of Nevada
11. 9/30/88 Report of Examination prepared by Insurance Division of Humana Health Insurance of Nevada
12. 7/21/89 Report of Examination to Determine Compliance with Assembly Bill 289 and 278 of Humana Health Insurance of Nevada
13. 8/31/89 Proposed amended Report of Examination to Determine Compliance with Assembly Bill 289
14. 10/18/89 amended 3/21/1990 Examination of Humana Health Insurance of Nevada

15. 3/3/89 Partial Transcript of proceedings of Senate Committee on Commerce and Labor Meeting
16. Nevada Division of Health Resources and Cost Review, Nevada Major Hospitals: 1986 Information
17. Report of Nevada Average Hospital Charges for the period 1/1/87 through 6/30/87 as prepared by Nevada's Division of Health Resources and Cost Review
18. 5/15/89 report of the Commissioner of Insurance re: Analysis of AB 289
19. Humana Health Insurance of Nevada, Inc. Actuarial Memorandum for the year ending 12/31/87 by David W. Wille, FSA, MAAA, Chief Actuary
20. 6/15/88 memo to Gail Knopf, Rocky Lubbers from Penny Nader re: Monthly Mutual Tapes
21. 1/26/89 letter to Teresa Rankin from David Wille re: Premium Rate Formula For Humana Health Insurance Company of Nevada
22. 2/3/89 letter from John Egermayer to Teresa Rankin re: Response to examination by the State of Nevada completed 9/30/88 and accompanying cover dated 1/3/89
23. 3/31/89 memo to Larry Cash from David Wille re: Best Auto Glass
24. 4/10/89 memo to Jim McCready from David Wille re: Nevada Rate Formula
25. 5/2/89 letter to David Gates from Larry Cash re: Actuarial Examination Review
26. Comparative Analysis of Hospital Data for the Years Ended June 30, 1987 and 1988
27. Report reflecting patient days, Charges and Discounts for HMO/PPO programs for August 1988 vs. 1989

28. Report reflecting patient days, charges and discounts for HMO/PPO programs for August 1987 vs. 1988
29. Discount Analysis for YTD August FY 86 for Humana Hospital Sunrise
30. Discount Analysis YTD 8/88
31. Schedule reflecting Humana Care Plus revenues and discounts at Humana Hospital Sunrise for the period 7/88 to 12/88
32. Testimony of Samuel Hazen during trial of Humana vs. Hemmeter
33. 9/16/87 Memo from Rob Leo to Steve Monaghan re: Methodology for Base Year Net Revenue for 7/1/86 to 6/30/87
34. 5/22/86 Memo from Mike O'Brien to Gary Metcalf re: Analysis of Discount Programs - April, 1986 including attached reports re: same
35. 8/15/85 report of audit of Mutual Administrators conducted by Humana Health Insurance Company of Nevada
36. 1985 Nevada Hospital Financial Annual Report for Humana Hospital Sunrise and MOB's
37. 2/1/85 Memo to Gary Hill from Jerry Anderson re: Nevada Hospital Financial Quarterly Report
38. 6/26/85 letter from Roger Collins to Teresa Rankin re: clarification of alleged overcharging of Champus
39. 7/15/85 letter from Roger Collins to Department of Human Resources enclosing response to additional questions regarding CON application submitted for Humana Hospital Sunrise for the purchase of a lithotriptor

40. 11/2/87 Memo to Don Stewart from Rob Leo re: private pay business increase with attached graph of private pay trends
41. 11/11/87 Memo from Rob Leo to Donald Stewart re: Patient Mix Trend including handwritten ledger
42. 2/16/88 letter from Larry Howard of HPN to Rob Leo re: proposal of 2/4/88
43. 3/3/88 Memo from Rob Leo to Gary Hill re: HPN Proposal with attached analysis
44. 5/3/88 Memo from Rob Leo to James Bohanon re: Salient Points of HPN Contract
45. 9/21/87 letter from R. G. Shannon Administrators to Rob Leo re: resolution of problems
46. 7/16/87 Memo from Rob Leo to Gary Hill re: Legislative Update
47. 9/16/87 Memo from Rob Leo to Steve Monaghan re: Methodology for Base Year Net Revenue for the period 7/1/86 to 6/30/87
48. 10/13/87 Memo from Rob Leo to Donald Stewart re: Impact of AB 289 on Humana Hospital Sunrise
49. 9/15/87 Memo from Rob Leo to Russ York re: Impact of AB 289 on Humana Hospital Sunrise
50. 1/18/88 Memo from Sam Hazen to Don Stewart re: Ab-289 Analysis
51. 1/4/88 Memo to Gary Hill from Rob Leo re: Humana Care Plus Discount re: recommendation that Humana Insurance reimburse Humana Hospital Sunrise $600.00 per diem for all Humana Insurance patients
52. 10/27/87 Memo to Donald Stewart from Rob Leo re: AB 289 Discussions with Scott Mayne

53. Comparison of AB 289 Revenue Reduction for Non-Medicare/Medicaid for Valley Hospital, Humana Hospital Sunrise and Desert Springs Hospital
54. Business Plan Analysis FY 85-FY 89 - Board of Directors Meeting 7/12/84
55. Master Policy HCP-84-NV-1
56. Policy GP-1000
57. Hospital Participation Agreement between Sunrise and Humana Insurance
58. Business Plan Analysis FY88 - FY90 - Board of Directors' Meeting 9/10/87
59. 10/13/87 Memo to Donald Stewart from Robert Leo re: Impact of AB 289 on HHS
60. 9/16/87 Memo to Steve Monaghan from Rob Leo Re: Methodology for Base Year Net Revenue July 1, 1986 to June 30, 1987
61. 7/12/88 Memo to Larry Cash from Beth Grice Re: Valley Hospital Reserve Statement
62. Analysis of Department of Insurance Complaint Against Humana
63. 6/17/87 Letter to Gregory J. Barlow from Dennis Kennedy re: Humana Subpoenas
64. Status Report from Bear Stearns for Humana, Inc.
65. Industry Report from Morgan Securities dated 12/12/86
66. Hospital Management & Services Progress Report from Morgan Stanley, dated 11/25/86
67. 1986 Annual Report for Humana, Inc.
68. 7/12/88 Memo from Beth Grice to Larry Cash

69. Analysis of Department of Insurance Complaint Against Humana

70. 4/30/87 Memo to David Jones from George Atkins re: Nevada Legislation

71. Humana Inc. Financial Analysis (Profitability of Group Health Division)

72. Financial Analysis - Humana, Inc. (Geographic)

73. Financial Analysis - Humana, Inc. - Income Statements for Selected Years 1976 -1985

74. Hospital Data, 1976 -1985

75. Explanation of Benefits for Helen Snelius Staves

76. 4/22/85 Memo from Larry Cash to Market Offices Sales & Operations Managers re: Financial Information with attached reports reflecting Budget Income Statement Summary (March, 1985), Group Health Division - Inpatient Utilization Report for May, 1985, Report reflecting Groups and Subscribers for Current Period, Fiscal 1985 year to date and Cumulative from Market Opening, Summary of Claims Analysis as of 10/84

77. 11/29/84 Memo from Larry Cash to Carl Pollard re: Humana Hospital Utilization

78. 12/7/84 Memo from Larry Cash to Carl Pollard re: Humana Hospital Utilization

79. 12/10/84 Memo to Market Operations Managers from Larry Cash re: Humana Hospital Utilization

80. 7/16/85 Memo to Brenda Bryant from Gloria Luber re: Printed Marketing Material Impact for companies with 5 - 9 employees

81. Certificate dated 8/22/85 authorizing a capital contribution in the amount of $1,500,000.00 from Group

Health Insurance, Inc. to Commercial State Life Insurance Company

82. 10/9/85 Memo to Regional Operations and Sales Directors from Diane Millett re: Financial Reports.

83. 10/22/85 Memo from John Reilly, Rich Robinson to Larry Cash re: Las Vegas Revenue understatement of June, 1985 through October, 1985 billings for the Police Protection Association

84. 3/17/86 Memo to Larry Cash and Wes Burbank from Robert J. Lubbers re: Trip Report - Mutual Administrators' Claims Audit - Nevada Markets

85. Plan Summary - out of pocket costs as of 2/1/86 for Humana Inc and Humana Health Insurance of Nevada, Inc.

86. 4/7/86 letter from Larry Cash to Department of Insurance re: Quotes, Rates - Small Group Product

87. 5/21/86 letter from Robert Lubbers to Michael Manges re: Calculation of Per Diem and Percentage of Charges, Participating Hospital Payments

88. 4/16/86 Memo to Betty Chowning from Joe Lawrence re: Incorrect payment of Non-Humana Participating Hospitals in the Nevada Market with attached back up documentation

89. 6/13/86 Minutes of Special Meeting of Board of Directors of Group Health Insurance, Inc. authorizing a $16,000,000 capital contribution from Humana, Inc. to Group Health Insurance, Inc.

90. 6/16/86 Memo from Robert J. Lubbers to Joe Lawrence re: Nevada Market Reserve Calculation

91. 7/17/86 letter from Michael Manges to Frank Guisti attaching examples of how claims for Humana Participating Providers are being paid

92. 9/25/86 Minutes of a Special Meeting of the Board of Directors of Group Health Insurance, Inc. acknowledging receipt of a $51,498,979.88 capital contribution from Humana, Inc.

93. 12/9/86 Minutes of a Special Meeting of the Board of Directors of Group Health Insurance, Inc. acknowledging receipt of a $57,000,000 capital contribution from Humana, Inc.

94. Documentation re: various assertions and facts regarding Humana Hospital Sunrise

95. 4/12/84 opinion of the Attorney General re: Humana's proposed practices of eliminating deductibles and/or copayments when the insured utilizes a particular hospital

96. Key Ratios Comparisons - Nevada Hospitals vs. National Average - Inpatient only

97. 1/28/87 letter from Dr. Soper to Fellow Physicians of Humana Hospital Sunrise and Medical Staff

98. 3/13/87 Marketing and Public Affairs Campaign for Humana Hospital Sunrise prepared by Nelson/Padberg Communications

99. 5/15/87 letter from David Jones to Colleagues enclosing his remarks when announcing steps taken to the protect Humana against regulatory harassment by the Bryan Administration

100. 5/15/87 memo to the file from Joseph A. Murray, Chief Investigator - Insurance Fraud Unit re: meeting with F.B.I. personnel

101. 9/18/87 Memo from Joe Shutts to Rob Leo re: Humana Care Plus Patients for Sunrise

102. 9/9/87 Memo from Joe Shutts to Larry Cash re: Humana Care Plus Patients for Sunrise

103. 12/30/87 Memo to Larry Cash from Douglas R. Carlisle re: Meeting with Nevada Department of Insurance

104. 4/1/88 Memo to Mike Manges for Joe Lawrence re: renewing Groups After January 1, 1988

105. 12/13/88 letter from Don Penney, Associate Actuary to State of Nevada, Department of Commerce, Life & Health Division re: UCR Schedules of Humana Medical Plan of Nevada, Inc.

106. 3/89 Narrative Report of the Enrollee Attitude Study Concerning Humana Hospital Sunrise prepared by The Gallup Organization, Inc.

107. 3/8/89 Memo to Neal Westermeyer, John Seagle from Elroy Schuler re: Las Vegas Class Action Suit Study

108. 3/10/89 Memo to Don Stewart from Paul Carter, Medicare Manager - Humana Gold Plan re: Affects of Adverse Publicity

109. 3/22/89 Memo from Neal Westermeyer to Wayne Smith re: Las Vegas Awareness of negative publicity surrounding Humana Hospital Sunrise

110. 3/20/89 Memo to Neal Westermeyer from Judi Farmer Re: Las Vegas Awareness

111. 3/9/90 letter from Donald Stewart to Jerry Griepentrog setting forth Humana's Position on the Definition of "Billed Charges", Inclusion/Exclusion of Medicare and Medicaid Patients and Percentage of Increase in Gross Revenue per Admission Attributable to Increase in Acuity

112. State of Nevada - Big Six Hospitals, Financial Summaries

113. 7/12/90 memo from Gary Pullen to Trevor G. Smith re: Humana Insurance Company

114. 1988 newspaper article entitled "UMC to cite Humana for Refusing Treatment"

115. Newspaper article from the "Capsule" entitled "Successful test of insurance spells expansion"

116. Graph depicting Comparison of Nevada Hospital Data to Consumer Price Index

117. Information regarding Acute Care Hospitals Markup Ratio, Operating Margin Comparisons

118. Desert Springs Hospital, Humana Hospital Sunrise, St. Mary's Regional Medical Center, University Medical Center, Valley Hospital Medical Center and Washoe Medical Center Comparison of Payor Categories, 6 months ended 12/31/89

119. Notes and Assumptions in Compiling Information for Comparison of Payor Categories

120. Hospital Comparisons for the period 1/1/88 to 12/31/88 Ranked by gross revenue per stay

121. Nevada Major Urban Hospitals - Per Patient Day Information - Billed Charges

122. Key Ratio Comparisons - Nevada Hospitals vs. national Average - Inpatient Only

123. Newspaper article entitled "Humana Policy Known for Three Years"

124. Nevada Hospital Financial Quarterly Report - 1985

125. 8/12/86 L.F. Rothschild, Unterberg, Towin, Inc. basic report

126. 5/30/89 Memo to Dave Gates from Sharon Weaver re: Humana Health Plan, Inc. (proposed foreign HMO)

127. 5/2/89 Memo to Mr. Schmoutz from Sharon Weaver re: Review of the GP 1000 policies and enclosing information.

128. 5/2/89 letter from Margaret Thomas, Contract Analysis to Sharon Weaver of Insurance Division re: Merger of Humana Health Insurance of Nevada, Inc. into Humana Insurance Company

129. Nevada State Quarterly Report, Comparison of Calendar Years 1985 and 1986

130. Nevada Hospital Quarterly Report dated 10/17/87

131. Nevada Hospital Quarterly Report dated 2/3/88

132. Nevada Hospital Quarterly Report dated 4/29/88

133. Nevada Hospital Quarterly Report for the period 7/01/88 through 9/30/88

134. Nevada Hospital Quarterly Report dated 7/21/88

135. Nevada Hospital Quarterly Report dated 10/26/88

136. Nevada Hospital Quarterly Report dated 1/30/89

137. Nevada Hospital Quarterly Report dated 2/21/89

138. Nevada Hospital Quarterly Report dated 4/28/89

139. Effect of Billed Charges Rollback/Revenue Reduction Program based on 1986 Inpatient Financial Information

140. Analysis of AHA Statistics - 1986 Utilization

141. 5/20/87 Nevada Hospital Association - Testimony Before the Senate Human Resources Committee - AB 289 Proposed Amendments

142. 9/16/87 Memo from Rob Leo to Steve Monaghan re: Methodology for Base Year Net Revenue for 7/1/86 to 6/30/87 including summary of consolidated operating results for the three months ended November 30

143. 1/17/85 letter to Dennis Kennedy from Glen A. Reed, counsel to Desert Springs Hospital re: Humana Care Plus Insurance Plan

144. Various reports including In-Patient Utilization, Enrollment/Premium Statistics, Benefit Level Options for groups of 50+, Budget Income Statement Summary dated 4/85

145. Memo re: definitive statement as to how the disincentive is applied

146. July 8-10, 1985 Utilization Review Assessment, Las Vegas Market - General Findings

147. 8/21/85 memo from Dave Shoughrue to All Sales and Operations Managers re: Competitive Information

148. 3/3/88 Memo from Rob Leo to Gary Hill enclosing analysis of pre-tax implications of an HPN contract for 20,000 patient days

149. 12/6/88 memo from Rob Leo to Marty Schweinhart re: Culinary Contract with attached pro forma

150. Humana Hospital Sunrise H.C.P. Analysis, AB 289 Adjustments, Pathology Analysis - I AB-289, Humana Care Plus Analysis for July, 1986 through June, 1987, Humana Hospital Sunrise Humana Care Plus Analysis for July, 1988 through June, 1989

151. 7/18/84 transcript of hearing re: Certificate of Authority of Humana Health Insurance of Nevada -- Valley Hospital Medical Center, Petitioner

152. 11/13/87 letter from John Egermayer to Robert Evans, Insurance Division re: transfer of claims processing and payment from Mutual Administrators, Inc. to Humana Corporate Claims System, Louisville, Kentucky

153. Telephone message to Herschell from John Andris re: merger and documents regarding exam

154. 3/9/84 letter from FIB to David Reinhardt, Humana Investment Management Department re: receipt of $1,501,355.63 via wire transfer

155. 10/20/88 Agreed Upon Procedures Review of Humana Organization prepared by Laventhol & Horwath

156. 7/21/89 Report of Examination to Determine Compliance with AB 289 and AB 278

157. 7/26/85 Report of Examination of Humana Health Insurance

158. 9/30/88 Report of Examination of Humana Health Insurance

159. Report of Examination of Humana Health Insurance of Nevada, Inc.

160. Portions of transcripts from the depositions or hearings of the following individuals:

    a. Roger Collins;
    b. Larry Cash;
    c. David Jones;
    d. Carl Pollard;
    e. Robert Lubbers
    f. David Gates
    g. Samuel Hazen
    h. Henry Werronen

161. 29 U.S.C. §§ 1002(21), 1004(a)(1)

162. All other memos and documents referred to herein.

II. Summary of Opinion

A. ERISA Analysis

I have reviewed 29 U.S.C. § 1002(21), and understand that a person is a fiduciary with respect to an employee benefits insurance plan if that person exercises any discretionary authority or discretionary control respecting management of such plan, or exercises any authority or control respecting management or disposition of the plan's assets, or if the person has any discretionary authority or responsibility in the administration of the insurance plan.

I further understand that Judge Pro has ruled that the insurance contracts themselves are assets of the insurance plan. With that understanding in mind, and after reviewing the master contract, HCP-NV-84-1 and the Preferred Provider Agreement and its amendments (the Secret Agreement), I am of the opinion that, from an economic point of view, the Secret Agreement payment terms, specifically "Attachment B" to the Agreement, did have an economic affect on the payment provisions of the insurance contracts.

I am further of the opinion that the payment terms of Attachment B materially changed the financial obligation of Humana Insurance from what it was otherwise obligated to pay pursuant to the payment terms of the insurance contract.

I have also reviewed 29 U.S.C. § 1104(a)(1), and understand that an ERISA fiduciary must discharge its duties with respect to the insurance plan solely in the interests of the participants and beneficiaries, in accordance with the plan contracts.

I am of the opinion that a payment of hospital charges based on a percentage or a per diem to Sunrise Hospital by Humana Insurance according to "Attachment B" of the Secret Agreement was not in accordance with the payment

terms of the insurance contracts. Furthermore, I am of the opinion that payment of hospital charges based on a percentage or a per diem to Sunrise Hospital according to "Attachment B" of the Secret Agreement while calculating the working person's payment on full billed charges was not in the best financial interest of the working person.

Based on the ERISA statutes and the holding of Judge Pro in his July 8, 1991 Order that the co-payor class is entitled to the benefit of the discount arrangement, the above referenced financial information of the Defendants was reviewed to determine the full amount of the discount during the class years 1985, 1986, 1987 and 1988.

A. The damages for the co-payor class:

1. Since the Second Amended Complaint was filed I have calculated the discount received by Humana Insurance from Sunrise Hospital as set forth below.

1985:	$ 5,058,000.00
1986:	$15,621,000.00
1987:	$15,743,000.00
1988:	$13,018,000.00

The total of all such discounts for the class period of 1985 - 1988 equals $49,440,000.00.

2. Thereafter, the following interest calculations were done using a reasonable rate of return of five (5)% per annum on the total discount amount of $49,440,000 from 1985 forward, which totaled $15,396,000, using simple interest, and $15,761,000 if interest is compounded monthly. With simple interest at 5% the total co-payor damages were calculated to be $64,876,000, and if compounded monthly the total co-payor damages were calculated to be $65,201,000.

3. Defendants' alternative approach to calculating damages in terms of the amounts that co-payors actually paid to Humana-Sunrise rests on estimates by Defendants that are not reliable. In addition, proper calculation of those damages requires specific information for each co-payor that Defendants have never produced during the course of this litigation.

a. Defendants' calculations regarding the actual amounts of co-payments by class members are not reliable.

At one time in this litigation Defendants asserted in a sworn affidavit that plaintiff Marrietta Cade had paid only $87.72 of hospitals bills totaling $16,437.66:

> The records of Humana Health Insurance confirm that Robert Cade was hospitalized in October, 1987, at Sunrise and that he incurred a hospital bill in the amount of $16,437.66. All but $87.72 of that hospital bill was covered by the benefits of Group Policy 79201.

Affidavit of John R. Egermayer, dated May 30, 1989, in Defendants' Supplemental Brief in Opposition to Plaintiffs' Motion for Class Certification. During a deposition of Mrs. Cade, Defendants' counsel Paul R. Hejmanowski represented to her as follows:

> Q There's an affidavit, a written document under oath by a representative of one of the defendants who stated, in effect, that with respect to Mr. Cade's October 1987 hospitalization, that your net payment towards the hospital bill was approximately $87.00.

Cade deposition at 13 (lines 18-23). Mrs. Cade thereafter produced copies of her personal checks establishing that she had in fact paid $1,146.71 to Humana-Sunrise in 1987 rather than the $87.72 that Defendants alleged. The most striking aspect of this 1,307% error by Defendants is that if Mrs. Cade had not prudently retained her cancelled checks from

that period, Defendants' sworn statement would have gone unchallenged.

Mr. Egermayer's representations concerning hospital charges by Humana-Sunrise were incomplete as well. In addition to the $16,437.66 bill that Mr. Egermayer reported, Mr. Cade incurred another bill from Humana-Sunrise in 1987 in the amount of $1,182.60 for outpatient services. That was the charge for which Humana-Sunrise billed the Cades $146.71, an amount that Mrs. Cade remitted.

2. Defendants' estimates regarding the actual amounts of co-payments by class members include improper overpayments.

Humana-Sunrise's $146.71 charge to the Cades was improper. According to the terms of the Humana Insurance group health policy that covered the Cades, the most they were required to pay for covered medical services in 1987 was $1,000.00. Mrs. Cade paid at least $146.71 beyond that limit, an overpayment that Humana-Sunrise *to this day* has not returned. Mrs. Cade's overpayment demonstrates that Defendants cannot calculate actual copayments merely by assuming they were the lesser of (a) $1,000.00 or (b) 20% of the hospital's gross billed charges. If Defendants applied that calculation to Mrs. Cade, they would understate her copayments by $146.71.

This situation may be considerably worse with respect to co-payors other than Mrs. Cade. She wisely disregarded additional attempts by Humana-Sunrise to collect amounts greater than her coinsurance limit. Statements from Humana-Sunrise demonstrate that on one occasion the hospital demanded payment of $353.00 on Mr. Cade's inpatient charges, even though the statement itself indicated the Cades had already paid $1,000.00 toward those charges. On another occasion Humana-Sunrise demanded payment of $236.52 for Mr. Cade's outpatient charges. As noted *supra*, *any* charge from Humana-Sunrise for those outpatient services

was improper, given that the Cades had already reached their annual payment limit of $1,000.00

Other co-payors might have paid those bills, especially co-payors recovering from debilitating afflictions, or those preoccupied with the task of caring for relatives who were recuperating at home, or those in mourning for recently deceased relatives. If Mrs. Cade had paid those bills for her husband, her overpayment would have totaled $589.52, or 58.95%. In actual fact, Mrs. Cade paid both the $353.00 and $100.00 of the $236.52, then demanded refunds.

If Defendants assert that those overpayments were for non-covered expenses, then Defendants are required to demonstrate, with respect to each patient, specifically what the non-covered expenses were for. Defendants cannot merely rely on the sort of entry that appears on Humana Insurance's Explanations of Benefits (EOBs), stating that a given charge is for all non-covered items, without identifying those items and specifying the amount charged for each one. As an example, Humana Insurance sent the Cades an EOB dated May 5, 1986 that listed $6.05 in non-covered charges for "Hosp Misc" without offering any additional information. Given Humana Insurance's fiduciary obligations to the Cades, a conclusory entry of that sort was wholly inadequate, and allowing Humana Insurance to rely now on tens of thousands of similar entries would severely compound the error.

Similar examples arose in statements of accounts issued to the Cades by Humana-Sunrise. In one statement Humana-Sunrise listed a "total due" of $15,437.66, "estimated insurance" of $15,084.66, and a "patient amount" of $353.00. Another statement listed a "total due" of $1,182.60, "estimated insurance" of $946.08, and a "patient amount" of $236.52. The statements offered no additional information concerning the amounts not covered by insurance.

3. Defendants' estimates regarding the actual amounts of co-payments by class members include unfounded assumptions.

Defendants' estimates assume that Plaintiffs had to pay the lesser of (a) $1,000.00 or (b) 20% of the gross hospital charges. In many or most instances, however, a deductible applied to some of those patients' Sunrise charges. If the patient's policy required a $500 deductible, if he had incurred no medical charges during the calendar year before entering Humana-Sunrise, and if his hospital bill was $10,000, then the patient would have paid a total of $1,500 of the hospital charges — $500 deductible in addition to 20% of the $9,000.00 balance up to $1,000.00, or $1,000. If, however, that same patient had incurred $500 in medical charges before entering the hospital, he would have paid only $1,000 of the hospital charges.

The question, in other words, is what portion, if any, of each co-payor's deductible in a given year was paid to Humana-Sunrise instead of to other health care providers. Defendants cannot simply adopt some arbitrary amount and apply it as an average. A complete analysis would require determining, for each co-payor, the amount of other medical expenses the co-payor incurred prior to entering Humana-Sunrise.

A complete analysis would additionally require determining, for each co-payor, the amount of the deductible set forth in that co-payor's policy. The master policy that Humana Insurance filed with the Nevada Insurance Division indicated five deductible alternatives for Humana-Sunrise ranging from no deductible to $500.

A complete analysis would further require determining, for each co-payor, the amount of the stop-loss set forth in that co-payor's policy. The master policy that Humana Insurance filed with the Nevada Insurance Division indicated alternative stop-loss combinations involving four options per individual that ranged from $1,000 to $10,000 and four options per family that ranged from $2,000 to $20,000.

Defendants' estimates assume that each patient reached a stop-loss limit of $5,000 in billed charges. After a cursory review of paid claims for 1985 and 1986, however, my impression is that an insignificant portion of those claims reached $5,000.

Finally, Defendants are required to determine, for each co-payor, the percentage of co-payment set forth in that co-payor's policy. The master policy that Humana Insurance filed with the Nevada Insurance Division indicated four co-payment alternatives ranging from 10% to 40%. Although Plaintiffs are not aware of any group policies issued by Humana Insurance that required copayments other than 20%, Plaintiffs have not examined each of the thousands of policies at issue and cannot simply rely on an assumption by Defendants that all of them specified that percentage.

B. The damages for the premium payor class:

1. Based on the Annual Statements filed by Humana Insurance with the Nevada Insurance Department, I am informed and believe that the total premium charged by Humana Insurance in Clark County during the time period 1985 through 1988 was the following:

1985:	$21,434,100
1986:	$33,393,670
1987:	$29,065,217
1988:	$28,861,525

During the class period, 1985 through 1988, premiums totaled $112,754,512.

Assuming that the actuarial formula did not include an adjustment for any Sunrise Hospital discount, under the actuarial formula adopted at the hearing before the Insurance Department in 1984, premiums would have to decrease by 48% if the 89% discount had been constant during this time period. Stated another way, since the difference between no

discount and the actual discount given is 89%, and given 68% of the expenses were allocated to the hospital in the actuarial formula (reduced by the assumed 20% non-Humana hospital utilization in the actuarial formula because these projected non-Humana hospital billings would not be impacted by the "secret" discount), an additional 89% discount would produce roughly a 48% reduction (68% hospital adjusted by 20% non-Humana times 89% discount) to premiums.

If a 48% reduction is applied to these premium charges, the total reduction is $54,122,165. It should be noted that this figure approximates the total reduction that should be applied because the evidence suggests that hospital discounts were under 89% for a portion of the pertinent time period and exceeded 89% during certain pertinent time periods. It should further be noted that if the per diem charges for the GP-1000 series were $600 per diem as opposed to $125 per diem for the HCP-NV-84-1 (which some evidence suggests), this damages figure is slightly overstated depending on the amount of 1988 premiums allocated to the CP-1000 series and the differential between a $125 per diem and a $600 per diem.

2. If, on the other hand, Humana Insurance did incorporate a 30% discount into the actuarial calculation (despite evidence to the contrary), the premium damages would be slightly lower. If the hospital discount is increased to 89% under the actuarial formula adopted by Humana Insurance at the 1984 hearing, premiums would have to decrease by 32%, if the 89% discount had been constant during this time period. More fully, since the difference between a 30% discount and a 89% discount is 59%, and 68% of the expenses were allocated to Humana Hospital in the actuarial formula (reduced by the assumed 20% non-Humana hospital utilization in the actuarial formula because these projected non-Humana hospital billings would not be impacted by the

"secret" discount), an additional 59% discount would produce roughly a 32% adjustment (68% hospital adjusted by 20% non-Humana times 59% discount).

If a 32% reduction is applied to these premium charges, the total reduction is $36,081,443. It should be noted that this figure approximates the total reduction that should be applied because the evidence suggests that hospital discounts were under 89% for a portion of the pertinent time period and exceeded 89% during certain pertinent time periods. It should further be noted that if the per diem charges for the GP-1000 series were $600 per diem as opposed to $125 per diem for the HCP-NV-84-1 (which some evidence suggests), this damages figure is slightly overstated depending on the amount of 1988 premiums allocated to the GP-1000 series and the differential between a $125 per diem and a $600 per diem.

In summary, the premium payor damages, without interest, are $54,122,165.00 if a 30% discount was not passed on, and $36,081,443.00, without interest, if a 30% discount was passed on.

3. Interest on the premium class damages were calculated by using a rate of return of 5%. Computing simple interest at 5% per annum on $54,122,165.00 resulted in interest damages of $16,479,815.00 for total premium payor damages of $70,601,980.00.

Compounding interest monthly, using the above stated rate of return, resulted in interest damages of $16,908,-730.00, for total premium payor damages of $71,030,-895.00.

Computing simple interest at 5% per annum on $36,081,-443.00 resulted in interest damages of $10,986,542.00, for total premium payor damages of $47,067,985.00.

Compounding interest monthly, using the above stated rate of return resulted in interest damages of $11,272,487.00 for total premium payor damages of $47,353,930.00.

C. Hospital Costs

1. Nevada Hospitals Lead the Nation in Profitability During the Class Period

I have reviewed the 1987 and 1988 Annual Survey by the American Hospital Association, wherein Nevada hospitals are number one in the United States in terms of hospital profitability. The American Hospital Association's 1987 Annual Survey provides in pertinent part that the profit per day of Nevada hospitals was $63.44, the billed charges per day were $1,248.00 and the net revenue per day were $829.52. By way of comparison, the net national average for profit per day was $23.37. Nevada hospital profits per day were 270% higher than the average in the entire United States. Arizona, which borders Nevada, was ranked 23rd with profit per day of $26.23, billed charges per day of $929.33 and net revenue per day of $689.98.

A document titled "Analysis of AHA Statistics — 1986" [12017319] reported that Nevada hospitals ranked first in the nation per admission in billed charges, net revenue, and profits. The profits per admission for Nevada hospitals was $274. The second highest state had profits per admission of $133 — less than half as high as those in Nevada. It is interesting to note that the three most profitable states, Nevada, Florida, and Kentucky, are all Humana strongbeds.

The American Hospital Association's 1988 Annual Survey reports that the profit per admission of Nevada hospitals was $306.93, the billed charges per admission were $8,009 and the net national average for profit per admission was $146.36. Nevada hospital profits per admission were twice as high as the average in the entire United States. Arizona,

by contrast, was ranked 43rd with profit per admit of $82.14. In other words, crossing the state lines from Arizona to Nevada caused a 273% increase in profits per admission.

A report prepared by the State of Nevada entitled "Proposal for an Integrated Approach to the Nevada Health Care Issues" stated: "That Nevada currently has the highest hospitals costs in the nation is not a debatable issue. Every available data source has consistently ranked Nevada hospitals first in billed charges, net revenues and profits." *Id.* at 1. I concur.

2. Sunrise Hospital Leads Southern Nevada in Profitability.

I have reviewed the following reports relative to revenues of for profit hospitals in Southern Nevada:

a. Report from the Nevada Division of Health Resources titled "Nevada Major Hospitals: 1986 Information".

This report determined Humana Sunrise had the highest billed charge per day, $1,671.00. However the net revenue is not the highest in large part due to the discounts to Humana Insurance. This is evidence that the discounts materially affected the true profit picture for Sunrise Hospital by falsely depicting that Sunrise was not as profitable as it really was during this time period.

b. Report from the Nevada Division of Humana Resources titled "Hospital UB 82 System Information for the Period January 1987 through July 1987".

This report determined that Humana Sunrise had the highest average per charge, $4,559.00 of all for-profit hospitals in Southern Nevada.

c. Report from the Nevada Division of Humana Resources titled "Comparative Analysis of Hospital Data for 1987 and 1988."

Again, this report reflects the fact that Humana Sunrise had the highest gross revenue per patient of the for-profit Southern Nevada hospitals.

A Humana document titled "Key Ratios Comparisons" reported that Humana-Sunrise's return on investment as of December 31, 1986 was 42.2%, compared to 35.5% for Desert Springs Hospital and 31.5% for Valley Hospital. The national average was only 10.3%.

An example of the profits Sunrise was able to generate in Nevada is dramatically illustrated below. For the year 1986 the following information clearly shows the higher profit Sunrise was able to generate as a percentage of the entire Humana parent company's United States operation.

Per Laventhol report at ii		
Consolidated parent company income before income tax	$90,652,000	100.0%
Humana Sunrise income after add-back of home office costs and Humana Insurance discounts per Laventhol report	$39,891,000	
Humana Health Insurance of Nevada losses per annual report	$(2,812,000)	
Add-back of home office at 2.4% of revenue of $33,394,000	$ 801,000	
Combined Income Before Income Taxes	$37,880,000	41.7%

The combined income of $37,880,000 of Humana Insurance of Nevada and Humana Sunrise as compared to the combined income of $90,652,000 for all Humana operations in the United States, clearly shows that Humana Sunrise and

Humana Insurance of Nevada generated approximately 41.7% of the income of all Humana operations.

3. Humana's Denial of Sunrise's Leading Profitability Is Not True.

I have also reviewed the deposition testimony of David Jones as it relates to the profitability of Sunrise Hospital compared to other Humana hospitals. I specifically reviewed the testimony of Mr. Jones related to an internal memo from George Atkins to Mr. Jones concerning the Nevada Cost Containment legislation, and Mr. Jones' response to then-Governor Richard Bryan's efforts relating to cost containment. Mr. Jones responded to questions about his handwritten notations on the memo as follows:

Q. . . . And number three says, "When will we get to the substance, i.e., the Governor is lying for personal gain."

What did you mean by that?

A. I meant that he was demagoging the issue.

Q. And, for the record, would you explain your answer when you say demagoging the issue?

A. I think it's -- I don't believe I could say it any plainer than it's written here.

"i.e., Governor is lying for personal gain."

That's what I mean by demagoging it.

Q. Well, I guess what I was wondering, what was behind that statement. . . .

A. He was saying a lot of untrue things about our organization.

Q. Specifically, do you recall what he was saying that you took issue with? I mean, not the generalities, what

particular things did he say that you felt were just not true?

A. I would have to go back and check. I remember being very concerned that the things he was saying did not reflect the truth.

Q. O.K. Would it refresh your recollection if I indicated to you it's my understanding that the Governor was concerned that Nevada had very high cost and felt that the hospitals in Nevada were making too great a profit?

Do you recall anything in his allegations along those lines?

A. I do recall something about that, now that my recollection has been refreshed. He had made some outrageous claim about the profitability of our activities out there, which was just not true.

Q. Humana accounts for a -- Humana Sunrise, excuse me, accounts for a large portion of Humana's overall pretax profit on an annual basis; does it not?

A. What do you mean by large?

Q. Above ten percent?

A. I don't think so, not near ten percent.

Q. Do you know if it's ever amounted to forty-four percent of your reported pretax profit?

A. The -- it's never amount to forty-four percent of the profits of the profitable parts of our business.

In the year in which we took the large writeoff, which was over a hundred million dollars after tax, and closer to two hundred million dollars before tax, that reduced the total company profits to something like fifty-six million dollars, and there were many hospitals

in that year which were quite profitable that weren't related to the insurance writeoffs that we've talked about, so that you could have said as of any hospital that was profitable, that its profit compared to the total profit of the company was large.

But if you added all those percentages up, it would have come to a figure many times the total profit of the company. It was only because of the writeoffs in that -- in that year.

Q. So, am I understanding you to say, in essence, that the pretax profit reported by Humana Sunrise was not taking into consideration the pretax profits of the entire company?

A. I'm saying you're putting apples and oranges together.

In that year, 1986, all of the hospitals together had a profit that was substantially greater than the two hundred million dollars of writeoffs, and that if you subtracted -- let me just say that among the profitable parts of the company, among the hospital division, the Nevada hospital profits were nowhere near forty-four percent.

Q. Let me see one moment here.

The reason I brought that figure up is because I had seen that in a report that was generated by Laventhol & Horwath that indicated those numbers, and, apparently, got those from the Annual Statement of Humana, Inc., and the statements -- or Annual Profit and Loss Statement from Humana Sunrise.

A. I just explained exactly how it occurred.

Q. I understand what you're saying, but I want to make sure that you can look at the document and after having seen the report, see if again that conforms to

your understanding of where the State of Nevada got those numbers. . . .

Mr. Jones, . . . I'm going to show you a binder that I'll refer to the Exhibits "M" as in master documents, which is on the spine. And, that is M-14.

(Whereupon the above-mentioned instrument was tendered).

And, ask you to look at the third page of the analysis, when you get it -- yeah, you're on it -- and it's the first indented paragraph under the paragraph at the top, "In 1986, the consolidated pretax income."

Do you see that, sir?

A. Yes, I see it.

(Witness complies with request of counsel.)

Q. Again, after having looked at this statement by Laventhol & Horwath, does that coincide with the analysis you just gave me as to where Laventhol came up with the numbers?

A. I can't speak for Laventhol. I don't know anything about Laventhol. But I can tell you -- there's two things.

First, the amount of pretax profit for Sunrise Hospital is itself misleading, because it doesn't include the totality of the operations that comprise the activities there -- the office buildings; the outpatient centers -- they've taken one entity and taken one piece of one entity to get the profit of the -- of this -- what they call Sunrise.

So, there's a deception in that.

The second thing --

Q. Just to clarify --

A. The ninety million dollars of pretax profit is after the writeoffs that I described to you.

All the hospitals together would have created percentages that came to many times a hundred percent, if this methodology were used.

This is comparing apples and oranges.

Q. Right. And, like I said, I wanted to make sure that you could look at this, and so you could -- after having looked at this, go through this same analysis and make sure I understood you.

But going back to the one thing you said about the thirty-nine million dollars, that being just Sunrise Hospital. How do you -- as opposed to the other related buildings and operations, how do you know that from this particular document?

A. Because I've heard this canard before.

. . .

Q. Did you understand that after the writeoffs in 1986, approximately -- obviously, you don't have it here in front of you -- that the pretax profit of Humana, Inc. was around ninety million dollars?

A. I believe that that's what this means. But when it says Sunrise in that phrase, the profit reported for what I call Sunrise, which is that bundle of assets that compromise the hospital and its attendant, contiguous, integrated operations -- I'm not talking about insurance, now, I'm just talking about the operation of the hospital and the medical office buildings and the outpatient centers around there -- the figure is inflated.

Q. Do you know how much it's inflated by?

A. Somewhere in the neighborhood of five to ten million dollars.

That was one of the complaints I had about the Governor, because this was the -- this is one of the lies that the Governor was telling, that Sunrise Hospital was contributing some enormous proportion of the company's profits, which was simply not true.

Q. Would you agree, then, that the forty-four percent of the profits, if they had been contributed by one hospital out of eighty-seven, would have been an enormous amount, using your term of the word enormous?

A. It would have been a very significant amount.

. . .

Q. And the reason that that impression is incorrect is, at least in your mind, is because of the huge losses that Humana suffered on the insurance side?

A. That's nothing necessarily to do with what the condition is.

What it's untrue is, because if you took the percentage of the ninety million dollars contributed by each hospital, it would come to far more than one hundred percent.

Q. Oh, I see.

A. Therefore, no one hospital could conceivably have contributed the percentages claimed.

. . .

Q. O.K. There's another statement in the last sentence of this paragraph we were just discussing that Sunrise was also Humana's most profitable hospital in 1985.

Do you know if, in fact, Humana was -- or excuse me, I got that backwards -- if Sunrise was Humana's most profitable hospital in 1986?

A. I don't recall. I testified earlier that it tends to be number one, two or three, and that the market tends to be in the top five.

. . .

There are several statements made by Mr. Jones which I believe to be inaccurate. First of all, he says that the Governor is lying because Sunrise does not account for a large portion of Humana's overall pretax profit. Specifically, he says it does not account for even "near ten percent".

Furthermore, when presented with the report prepared by Laventhol & Horwath for the State of Nevada, on which Governor Bryan was apparently relying, Mr. Jones states that the pretax profit for Sunrise is misleading and deceptive because it doesn't take into account the writeoff incurred by the Insurance Division in 1986, and doesn't include the "totality of the operations that comprise the operations [in Nevada]."

As set forth in full in Section C(2) above, I believe that Sunrise contributed far more than ten percent (10%) of the parent company's (Humana, Inc.) pretax profit, and that the report of Laventhol & Horwath, for the most part, takes into consideration the issues raised by Mr. Jones in reaching a conclusion. In fact, in my opinion, if anyone was being deceptive in analyzing profitability, it was Sunrise because it appears that it was trying to shift approximately $15,000,000 in secret discounts to what should have been Humana Sunrise's profits during a time of cost containment legislation, thereby artificially reducing the true profit picture for the Hospital.

Furthermore, some of Humana's own documents confirm the enormous profitability of Sunrise year after year. For the year 1985 the State of Nevada, Department of Human Resources and the "Medicare Intermediary Audit of Home Office Costs" indicates that Sunrise was the revenue leader:

HOSPITAL	BEDS	BILLED CHARGES	CONTRACT ADJ – BAD DEBT
Sunrise, NV	679	$194,272,000	$(70,031,000)
Biscayne, FL	402	$ 60,640,000	$(23,581,000)
Augusta, GA	362	$ 64,132,000	$(18,431,000)
Phoenix, AZ	300	$ 46,551,000	$(9,628,000)
S. Brow, FL	269	$ 24,535,000	$(4,809,000)
Ft. Walton, FL	263	$ 45,048,000	$(14,419,000)
Hoffman, IL	249	$ 47,446,000	$(9,632,000)
Cypress Gd., FL	245	$ 37,385,000	$(10,034,000)
Mt. View, CO	241	$ 23,789,000	$(5,965,000)
Bayside, VA	237	$ 44,968,000	$(16,842,000)
Lucerne, FL	232	$ 65,719,000	$(15,379,000)
St. Pete, FL	219	$ 39,203,000	$(13,827,000)
Daytona Bch, FL	214	$ 25,222,000	$(6,894,000)
Brandon, FL	204	$ 52,843,000	$(14,034,000)
St. Lukes, VA	200	$ 36,258,000	$(12,975,000)
Sun Bay, FL	192	$ 36,810,000	$(20,771,000)
Aurora, CO	189	$ 36,810,000	$(5,632,000)
Bennett, FL	178	$ 52,408,000	$(17,112,000)
Clinch Val, VA	135	$ 40,802,000	$(14,384,000)
	5,010	$974,841,000	$(304,380,000)

Finally, a Humana comparison by profits per admission "study group" again concludes that Sunrise is unquestionably the profit leader in the chain. In the report marked "received", January 7, 1987, the report concludes:

> When compared to the average for all Humana hospitals in the study group, Humana Sunrise in Nevada clearly shows a disproportionate revenue and profit picture on a per admission basis, as follows:
>
> Thus, while Humana Sunrise's operating expenses per admission were just 125.8% of the group average, its profits per admission were 229.5% of the average for all Humana hospitals in this study group.

Apparently, even Humana, Inc. could not understand how Sunrise could be so profitable, referring to the revenue and profit Sunrise generated as "disproportionate".

4. Sunrise Is the Most Profitable Hospital on a Per Inpatient Day Basis.

I have been informed that some representatives from Humana claim that Sunrise Hospital is not the most profitable hospital for the parent company on a per inpatient day basis. In other words, I have been informed that some Humana representatives have stated because Sunrise has far more beds than any other Humana hospital it naturally generates more revenue, but when you divide the profit at Sunrise by the number of annual inpatient days, Sunrise's profits are much lower than the profits compared to some smaller Humana hospitals.

I have reviewed the Nevada Department of Humana Resource's survey of Humana Hospital chain's most profitable hospitals in 1985. Based on my review of the above, and the occupancy levels at the listed hospitals in 1985, Sunrise Hospital was the second most profitable hospital of all Humana hospitals on a per inpatient day basis, with the exception of Humana's Aurora, Colorado hospital.

My calculations indicate that Sunrise generated a profit of $238.00 per inpatient day, while Aurora generated a profit of $256.00 per inpatient day. The next closest hospital was in Lucerne, Florida, generating a profit of only $200.00 per inpatient day. However, on review of other Humana internal memos provided to the State of Nevada, it was determined that Humana's Aurora, Colorado hospital did not have a symbiotic relationship with a Humana Insurance Company in 1985, and consequently no discounts were provided to the Aurora, Colorado hospital. If Sunrise had not given approximately $5,000,000 in discounts to Humana Insurance in

1985, then Sunrise would have far outstripped Aurora, Colorado as the most profitable hospital per inpatient day in Humana's chain in 1985.

D. Sunrise Claimed Incremental Costs of $125.00 Per Diem.

During the deposition of Gary Metcalf, he claimed that the $125.00 per diem Sunrise Hospital agreed to accept from Humana Insurance, starting in 1986, was sufficient to cover the hospital's incremental costs incurred per Humana insured inpatient. Other Humana representatives appear to have verified this fact, including the Humana Group Health Insurance Vice President of Finance, Larry Cash.

> I recognize $125 is considered an incremental cost. . . ."; $125 was a rate we adopted to try to make sure there would be no profit left in the payment rate to the hospitals.

Cash Deposition at 227. Mr. Cash also testified:

> Q. I guess where this all stemmed from is, you said you had an unusual discount arrangement in 1986 because you recognized a huge loss in the group health division, correct?
>
> A. No. What I said was in 1986 we increased the discount because we set up a large reserve for losses in the future. We increased the discount which brought the reserve down and that became the payment rate from that point forward.
>
> The reason we increased the discount was, in our opinion *we had to eliminate all the potential profit* from the consolidated into Humana. And if we would have kept the payment rate that was adopted or in place prior to setting up the reserve, there would still have been profit left on the books at hospital so we had to eliminate that transaction *so it would not look as if*

> *from an accounting perspective we set up a reserve which called for payment rates from the insurance company to the hospital and then the hospital then make a profit off of that payment rate.*

Cash deposition at 223-24 (emphasis added).

If in fact Sunrise covered its incremental costs with the $125.00 received from Humana Insurance, then any deductible paid by the insured working person to Sunrise, and any portion of the 20% coinsurance of the full billed charge that Sunrise received from the Humana insured working person, was profit to the hospital.

This arrangement would have the effect of allowing the hospital to cover its costs and possibly even make some profit, while the insurance entity would have a great competitive advantage over other insurance companies by paying *far* less for its insured's hospitalization.

E. Humana Insurance Profited by Withholding or Delaying Payments to Non-Humana Hospitals, including Valley Hospital and Womens Hospital.

Humana Insurance adopted a practice of withholding or delaying payments to non-Humana hospitals, including both Valley Hospital and Womens Hospital, as early as November of 1984. In an interoffice memorandum from Joe Lawrence to John Morse dated November 19, 1984, he noted: "I have also instructed Mutual Administrators to notify me of any claims filed from a non-participating hospital before they initiate payments if benefits would exceed $500.00." *Id.* at 2.

In an interoffice Humana memorandum from John Morse to "All Market Operations Managers" and copied to Henry Werronen, Richard Mastaler, and Larry Cash, et al., dated March 22, 1985, Mr. Morse directed:

> All of our group insurance and prepaid health plan contracts contain a provision stipulating that waivers, rebates, discounts and other amounts which the covered individual is not obligated to pay are not considered covered benefits. Therefore, the disincentive deductible and copayments are applied after the amount waived or discounted is excluded from the total bill.
>
> If the competitor hospital "waives" the required copayment and deductibles due from the covered Humana Care Plus enrollee, these would be eliminated from covered charges and we would apply the deductibles and copayments to the remaining balance. In effect, we would take the deductibles and copayments twice and if the second deductibles and copayments were waived we would take them again and so forth. The patient must pay the deductibles and copayments for them to be considered covered benefits whereby we would pay the remaining portion after the deductibles and copayments have been paid by the covered individual.
>
> Any hospital which publicly communicates that they will be waiving copayments and deductibles for Humana Care Plus patients should be told of this feature and how we are planning to administer it. *At the present time we are pending all claims from non-participating hospitals and in the case of deductibles and copayments being waived, these claims will be paid as described above.*

Id. at 1 (emphasis added). In a responsive interoffice Humana memorandum from Larry Cash to Henry Werronen and John Morse, et al., dated March 29, 1985, Mr. Cash directed managers to provide "a listing at the end of each month . . . indicating the hospital, market, total charges, and total covered charges for *any claims for which we are*

not paying as a result of non-participating hospitals waiving disincentive deductibles and copayments." *Id.* at 1 (emphasis added).

In an interoffice Humana memorandum from Joe Lawrence to Karen Sholtis, copied to John Egermayer, dated May 31, 1985, Mr. Lawrence noted, at 1:

> Local hospitals continued to waive our disincentive and co-insurance. I feel I need some legal direction since they are not formally waiving the charges, in fact they are billing the individual for the full amount not paid by our insurance company, however there has been no evidence that they make any efforts to collect the disincentive portion from the member.

In an interoffice Humana memorandum from Joe Lawrence to Pam Peale dated August 16, 1985, Mr. Lawrence directed: "Please pend all payment of claims from Valley Hospital and Womens Hospital for Humana Care Plus insurends until further notice." *Id.* at 1.

Three days later, in an interoffice Humana memorandum from Joe Lawrence dated August 19. 1985, Mr. Lawrence directed: "All waivers received with services performed at Valley Hospital or Women's Hospital will be *investigated, but not returned to Mutual Administrators with a decision until further notice*." Id. at 1 (emphasis added).

In a letter from Joe Lawrence to Tom Peacock, Director of Personnel for the Sahara Hotel & Casino, dated August 22, 1985, Mr. Lawrence attempted to pressure the Sahara into persuading its employees not to use non-Humana hospital facilities, especially those that waived their charges to insured patients:

> After six months into the contract with your group, we find that you utilization of Humana Hospitals is only 56% of the hospital claim dollar. If this trend continues

> it will result in an extra 5% increase in your premium at the end of the year.
>
> I feel that the major problem is that your employees have been misled by competing hospitals. Many hospitals are waiving the disincentive to the employee, therefore the employee feels that there is no increased cost. However, increased use of non-participating hospitals will result in an increase of 5%. I trust you will present this information to your employees with your input.
>
> Enclosed are copies of examples of efforts by competing hospitals to use their facilities.

Id. at 1.

In an interoffice Humana memorandum from Joe Lawrence to John Morse, copied to John Egermayer, et al., Mr. Lawrence quoted at length from the letter Mr. Peacock drafted to Sahara employees in response to Mr. Lawrence's request:

> Don't hurt yourself in the long run as well as your co-workers by going to a hospital or out-patient facility other than your doctor's office or Sunrise unless it is an emergency.
>
> There are hospitals in town that are in fact waiving the penalty imposed by Humana for using hospitals other than sunrise. Some hospitals are suggesting that our type of program somehow disrupts the established relations with both physicians and hospitals. This simply is not true! You must explain that if you or a dependent must be admitted to a hospital, except in emergency situations, you will have an economic interest in going to Sunrise.
>
> The time for you to get involved in these kinds of decisions is now! Don't jeopardize this important bene-

fit which currently does not cost you any contribution. Hospital costs must be controlled. Our program can only be successful if you do your part.

Id. at 1.

In addition to the foregoing, a July 12, 1988 memorandum from Beth Grice demonstrates that Humana Insurance withheld the payment of claims from Valley Hospital, a non-preferred hospital, until Humana Insurance had proof that the patient was billed and that the patient had paid the co-payment to Valley Hospital in accordance with the punitive terms of the Humana Insurance contract. For example, in that memorandum Humana Insurance set forth the amounts recommended to be held back for Valley Hospital claims as follows:

Month	Valley Hospital Reserve
3/86	476,750
4/86	304,860
5/86	304,860
6/86	265,286
7/86	414,826
8/86	274,478
9/86	163,414
10/86	126,986
11/86	68,296
12/86	0

Not only was this practice punitive to the patient in the form of high costs, it also had the potential of ruining the patient's credit rating, as the patient is ultimately responsible for the entire bill if not paid by the insurance company. In addition to the detrimental effect to the patient, Humana Insurance also benefited to the extent it had the ability to earn interest on the funds withheld from Valley Hospital by holding those funds in a reserve account.

F. Humana Used Deceptive and Misleading Financial Reports and Documents

In reviewing the Laventhol report (#002387 and #002392) the auditors relied on the Humana Sunrise Medicare cost reports and Nevada hospital quarterly reports submitted to the State of Nevada in reconciling the hospital discounts. These reports reflect that discounts were recorded on a regular basis during the year.

In reviewing the internal memo dated September 16, 1987 from Rob Leo, it states that the Humana Insurance Company discount was changed in August of 1986 from 56% to 89% plus additional bad debts. However, this additional discount approximating $6,300,000 and an unknown amount of bad debts does not appear to be reported in the financial data provided by Humana Sunrise to the State and relied on by the Laventhol auditors. Accordingly, the Humana Sunrise reports appear to contain incomplete and misleading information.

This conclusion is further supported by the internal discount reports prepared by Humana itself in 1986 that do not indicate that an 89% discount was being taken during the majority of 1986. More specifically, Humana has produced a document entitled "Humana Care Plus" and designated as document number 02007942 which ranks the Humana hospitals by fiscal year admissions and states the total payments to each Humana hospital by Humana Insurance and the total discounts given by Humana Insurance to each hospital. The information provided for Humana Hospital Sunrise for the "YTD FY '86" period was as follows:

Revenue $13,563,900 Discounts $5,345,200

The memo to which this information is attached implies that the foregoing data is apparently for a portion of the 1986 fiscal year, (September 1985 through April 1986).

It is further my understanding that testimony of certain Humana employees describes the calculation and reporting of such discounts, including certain back-up calculations for the Quarterly Reports. It is also my understanding that discounts provided to other entities such as Blue Cross are included with the Humana Care Plus discount reported to the State of Nevada. That fact is important in order to determine the total discounts provided to all insurers or employer groups and verify if the Humana Insurance discount is included in the discount reported. The testimony regarding the discount reporting is as follows:

Q. For whom are these documents prepared?

A. The State of Nevada.

Q. Any specific agency within the State of Nevada?

A. I don't remember the exact title. You can maybe help me here. The Division of Health Resources and Cost Review, I believe.

Q. Department of Human Resources, Health Resources and Cost Review?

A. Right.

Q. And what was the purpose of preparing these documents?

A. This was a standard quarterly report that was required by this agency.

Q. And there was a quarterly report for what entity?

A. For Humana Hospital Sunrise.

Q. Setting forth what sort of information?

A. This only shows a small portion of the entire report. The entire report encompassed financials and utilization information.

Hazen Deposition at 105-06.

I have been informed that these Quarterly Reports included the discounts that Humana Hospital was providing to Humana Insurance during these particular time periods:

Q. All right. I'll begin with 6B. Will you please turn to the second page of 6B. And do you see the entry for other contractuals?

A. Yes.

Q. Is that a sub-entry under the heading deductions from patient revenues?

A. Yes, sir.

Q. Can you state what the heading other contractuals indicates?

A. That is a category for non-medicare and non-medicaid revenue deductions. It would be, for example, HMO discounts, PPO discounts, workers' comp discounts, Champus discounts, et cetera.

Q. Would that include discounts to Humana Insurance?

A. Yes.

Id. at 108.

Hazen Deposition Exhibit 5-A reflects the following discounts in calendar years 1985 and 1986:

1985 TOTAL $19,118,570 1986 TOTAL $32,282,188

Mr. Hazen testified and the Quarterly Reports attached to the deposition as exhibits indicate total contractual discounts in the following amounts for the quarters indicated:

4th Quarter 1987	$ 9,939,196	4th Quarter 1988	$16,734,168
3rd Quarter 1987	$ 7,764,559	3rd Quarter 1988	$13,701,437
2nd Quarter 1987	$ 7,253,685	2nd Quarter 1988	$ 8,696,146
1st Quarter 1987	$12,188,691	1st Quarter 1988	$12,447,461
1987 TOTAL	$37,146,131	1988 TOTAL	$51,579,212

As explained above, the Laventhol & Horwath Report demonstrates that the discounts reported by Humana Insurance in the Nevada Quarterly Reports do not correspond to the discounts that Humana later claimed to have received in such quarters.

Additional evidence exists which appears to demonstrate further Humana's willingness to file incomplete and/or deceptive financial information with government agencies. For example, in a memo dated February 1, 1985, Humana Insurance appears to be very concerned that Humana Sunrise financial data (through the three-month period ending 12-31-84) reflects a net income of $3,500,000.00 after the losses from the physician buildings and an allocation of 48% for federal taxes.[1] Keeping in mind that during the 1985 legislative session the first real attempt was made to establish hospital cost containment regulations, these profits would have been $14,000,000 *NET OF BUILDING LOSS AND TAX*. If we compute profit before the 48% tax it is $7,300,000.00 for the three months or $29,200,000.00 on an annualized basis. Having been personally involved in the legislative committee hearings on cost containment in 1985, I know that at that time hospitals in Nevada were concerned about appearing to have generated high profits.

In light of the February 1, 1985 memo regarding Sunrise's very significant profits and the reference to the political realities at the time, I am of the opinion that Sunrise was attempting to distort its true profit picture to the State. This

[1] The corporate tax rate during this period was not 48%.

opinion is borne out in the letter dated February 5, 1985 (just four days after the internal memo) to Mr. Pepe, with the State of Nevada claiming that Sunrise could not submit quarterly filings because of some unspecified SEC requirement that the filings be audited. I do not believe there is any such SEC requirement, and Humana's assertion is belied by the fact that later on, when the 1985 profits were apparently was no longer an issue, Humana did in fact make quarterly filings with the State. It is my opinion that the February 5th letter was prepared as a delaying tactic to avoid the disclosure of excessive profits which may have increased the probability of passage of cost controls in 1985 to the detriment of Sunrise.

Additional evidence of Humana's deceptive accounting practices appears in the Quarterly Reports of Humana-Sunrise that stated its parent company charged the hospital $4,241,000 for "home office" costs in 1987 and $13,058,000 in 1988. Medicare disallowed a substantial portion of the 1986 costs. I believe Medicare has disallowed or may disallow a substantial portion of the 1987 costs as well. Those grossly inflated "home office" charges allowed Humana-Sunrise to under-report its profits during those years, and demonstrate both deceptive accounting practices and abuse of the Medicare program. Similar adjustments may be required in cost containment calculations.

G. The Discount Was Treated Inconsistently for Bonus Compensation.

It even appears that Humana employees recognized the deceptive nature of the secret discounts and complained to upper management to a point that changes had to be implemented to appease those hospital managers. In other words, the government regulators were apparently given the "discount adjusted" figures, but the hospital managers got

the benefit of the real figures when it came time to compute their bonuses. The following testimony is illustrative of the point:

> Q. Going back to the early days of the starting, '84, '85, of the insurance division, was -- did you ever perceive or have indicated to you that other people perceived that there was a conflict between the insurance division getting this so-called discount and that the hospitals were giving too much and the insurance company was asking for too much?
>
> A. Let me answer that in this way. There probably was always, or excuse me, there was perhaps some perception of that on the hospital manager's part. I never could quite figure out in my mind why. Mostly because the incentive compensation plans were all based upon budgeted results and the budgeted results either did have or would be adjusted for any pricing changes that we would have made. So, it really didn't make any difference whether it came from one place or another.

Pollard Deposition, Vol. I, at 82, 84. Mr. Cash also testified that Humana Hospital adjusted bonus compensation to hospital employees to circumvent the impact of the retroactive discount change in September of 1986:

> Q. Do you recall that it was ever adjusted based on the discounting practices at any time? The adjusted meaning the -- do you recall if the incentive bonus was ever adjusted due to or because of the discounting practices between the insurance company and the hospital?
>
> A. To the best of my recollection, there may have been some adjustments in 19 -- for the year 1987.

This treatment of the discount for bonus calculation purposes appears to be consistent with the way Humana

treated the discount in other financial documents, i.e. the "discount" was factored into the financials whenever or wherever it benefited Humana, Inc., but it was ignored whenever it did not. This is, in my opinion, further evidence of the deceptive nature of the treatment of the discount in the financial records of Humana.

I have also reviewed the insurance policy of Humana Health Insurance of Nevada, noting that the payments are to be based on usual and customary charges and that the insurance company's payment responsibility is based on paying an amount equal to 80% of these usual and customary charges. In accordance with the contract and under generally accepted accounting principles, the insurance company would pay an amount equal to the 80% and reflect a claims paid expense equal to that amount. Similarly, Humana Sunrise would receive payment equal to the 80% and record a reduction of that patient's accounts receivable. In fact, however, due to the retroactive discounts in 1986 and monthly discounts in subsequent years, the insurance company's internal accounting records, as represented by Humana and other officials, reflected a substantially reduced claims expense and a substantially larger discount. According to Larry Cash, Humana increased its discount to 89.1% effective September 14, 1987. The Annual Statement filed by Humana Insurance for that year, however, did not reflect that substantially reduced claims expense and substantially larger discount. The actual accounting transactions resulted in a shifting of profits from Humana Sunrise to Humana Insurance. In accordance with the contract in effect for these period, the recording of these transactions is not contractually correct and, therefore, is not in conformity with generally accepted accounting principles on a company-wide consolidated basis and especially on a business segment basis.

H. Humana Sunrise Benefited Enormously from the Secret Discount.

I have reviewed documents from the State Department of Human Resources relative to its computation of compliance with AB 289 for 1988. These computations included an adjustment in the base year 1986 for the pathology carve-out due to its exclusion from 1988 net revenue. An interoffice Humana memorandum from Robert B. Leo, Associate Executive Director of Finance, to Don Stewart, Executive Director of Humana-Sunrise, dated June 10, 1987 (#178204), noted that "While compliance with a 25% gross revenue reduction is mandated, several objectives/opportunities present themselves." *Id.* at 1. Mr. Leo identified one of those "opportunities" as follows: "Pathology - Separate billing arrangements are currently being negotiated which would reduce hospital expenses and revenues." *Id.*

Humana also included an adjustment to add back the Humana Insurance Company discounts. However, the discount added back assumed the GP 1000 policy was the only policy in effect for that year, when in fact the GP 1000 appears to have been a minimal factor in that year, as is reflected within the documents sent to the State on March 27, 1989 by Mr. Egermayer (#12017127-42). In my opinion, Humana's misrepresentation of the applicable discount in 1988 was an illegal act designed to circumvent AB 289. If the State had properly computed these discounts instead of relying on Humana's misrepresentation, then Humana's noncompliance with AB 289 would have been an excess of net inpatient revenue approximating $12,500,000. Pursuant to AB 289 § 55, subsection 7, the penalty for excessive inpatient revenues is twice the amount the hospital exceeds its required limit, or in this case, $25,000,000.00.

However, the State's method of computing the noncompliance was done without regard to the increase in pa-

tient admissions from 1986 to 1988, based on the State's understanding of the statute. This methodology differs from that of Humana Sunrise personnel who apparently took the increased admissions into consideration, as set forth in the memo dated October 13, 1987 from Robert Leo (#12011969). Giving Sunrise the benefit of the doubt, I recalculated my computations above so that the State's methodology for computing AB 289 is consistent with that of Humana Sunrise, and Humana's non-compliance with AB 289 was still in excess of net inpatient revenue by approximately $9,500,000, resulting in a penalty of $19,000,000.00 to Sunrise. Consequently, Sunrise had a great economic incentive to provide the enormous discount to Humana Insurance.

I. Humana Insurance's Claims That It Shared Discounts by Reducing Premiums Are Contradicted by the Facts.

In 1989 Humana Insurance presented the Nevada Department of Insurance with documents purportedly establishing that in 1987 Humana Insurance had passed along to its insureds the discounts that Humana Insurance received from Humana-Sunrise. The documents are attached as exhibits to the 1989 Report of Examination. After a review of those documents, however, I do not believe that they establish what Humana has claimed.

The first document is titled "Humana Health Insurance of Nevada Inc./Actuarial Memorandum/Year Ending December 31, 1987," and signed by David W. Wille and Larry W. Cash on April 14, 1989. The second-to-last paragraph of this document simply asserts that the analysis contained therein demonstrates that Humana Insurance passed on to its insureds the discount that Humana Insurance received from Humana-Sunrise. That assertion appears incorrect.

The second document is titled "Humana Health Insurance of Nevada Inc./Actuarial Memorandum/Year Ending

December 31, 1988," signed on March 25 and 24, 1989, by David W. Wille and Larry W. Cash, respectively, of Humana, Inc. Column One appears to set forth actual figures and reports a loss of $888,862. Column Two, labeled "For illustration Only," incorporates two modifications to the calculations in Column One. The first modification involves adding the discount of $14,272,640 to the benefits amount in Column One to arrive at benefits that would have totaled $40,969,011. The second modification involves simply adjusting premium revenues so that the loss in Column Two is the same as the loss in Column One.

This increase in premiums is a mere hypothetical, not grounded in reality or even possibility. It is my understanding that Humana Insurance had sold long-term policies that contractually committed Humana Insurance to charging certain premiums; it could not have increased those premiums unilaterally. Additionally, Humana Insurance almost certainly could not have sold policies with premiums that high. As Mr. Cash stated in his deposition:

> Q Do you believe that the premiums to Humana Care Plus insureds in the State of Nevada would have been $15 million higher in 1986 but for the discount Humana Insurance received?
>
> A That's a hypothetical question and I'm not for sure you'd have sold the premiums under that theory . . . .
>
> Q But you don't know if it would have been by $15 million?
>
> A What I'm saying is, I don't think we would have sold the premiums at $15 million higher.

Cash deposition II at 468-69.

The third document is a Statement of Actuarial Opinion prepared by James M. McCready of Coopers & Lybrand,

dated April 15, 1989. In that document Mr. McCready appears to state only that he reviewed the discount amounts and agrees that they were 90% and 75%. He does not appear to offer an opinion regarding whether those discounts were passed on in the form of reduced premiums.

Mr. Cash also testified as follows:

> Q. Okay. Did you adjust your premiums in 1986 then to reflect more or what your experience had been so that the premiums then would, in fact, cover future claims?
>
> A. Premiums in 1986 going forward, most of the premiums in 1986 had been set and we slowed down the sales activity. And we did change our payment -- our premium rate practices in 1986. We recognized we had some losses. Sometimes we did it timely and sometimes we waited when we recognized we needed a premium *increase*.

Cash Deposition at 223, 224 (emphasis added).

The claim that the "secret" retroactive discount of 89.2% in 1986 was passed along in the form of lower premiums is also inconsistent with testimony that there was a premium increase -- not a decrease -- in 1986. (Cash Deposition at 237, lines 20-23, stating "In '86 probably a rate increase"; 433, lines 13-18, stating "I believe we were increasing premiums [in November 1986]"; November 25 Morgan Stanley Investment Research Report, stating "In our opinion, Humana recognizes the errors it made with Care Plus and is in the process of correcting them. First the company is substantially increasing Care Plus premiums wherever possible" and that "Premium rates for existing unrestricted contracts and potential new ones have gone up 20 percent and 40 percent. . . .")

J. Humana's Bookkeeping Practices and the Application of the Secret Discount Appear to be a Kickback.

As Judge Pro explained in his July 9, 1991 Order, "The agreement between Humana Insurance and Sunrise Hospital on which Plaintiffs rely specifically provided for the discount rate to be the basis of charges to the insurance company, and the usual and customary rate as a continued basis for the Plaintiffs' copayments." (Order at 13). Judge Pro further noted that "The discount agreement between Humana Insurance and Sunrise Hospital meant that, although the insurance contracts provided for the insureds to cover 20% and Humana Insurance to cover 80% of hospital costs beyond the deductible, they were no longer percentages of the same figure." (Order at 15).

The above analysis by Judge Pro is consistent, from an accounting standpoint, with my understanding of the manner in which the fraudulent scheme worked. I have reviewed the HCP-NV-84-1 policy and the Humana discount reports to verify that, in fact, the discount was applied to the billed charges as Judge Pro indicated. In my opinion, and also consistent with Judge Pro's analysis, Humana Insurance should have been paying the co-insurance pursuant to the insurance contract which clearly stated to the public the percentage to be used when paying hospital claims. In my opinion, the secret agreement is not an agreement I could rely on as a CPA as it was hidden from the buying public and strictly between officers of Humana. Accordingly, with these facts, I would probably have to conclude that the discount is in fact an illegal kickback.

Furthermore, as a CPA I may have had some obligation, if I were doing an independent audit of Humana, to inform the proper Humana officer how the discount was being treated on the books, and withdraw from the engagement if necessary. Since the discount was noted in the audit report,

the auditors must have been aware of the kickback possibility.

I am further informed that Humana Insurance actually paid Sunrise 80% of the covered charges through a checking account funded for Mutual Administrators, Humana's third party administrator in Nevada. Thereafter, the insured would receive an Explanation of Benefits ("EOB") report from Mutual Administrators, or Humana Insurance, that confirmed to the insured working person that 80% of the covered charges were being paid by Humana Insurance.

This type of deception is a central characteristic of many "kickback" schemes in which the perpetrator creates a "fictitious" billing that is submitted to the victim of the scheme or is provided to monitoring authorities as the true statement for goods or services, when in reality a different payment arrangement or a "secret" discount has been agreed to between certain of the parties. For example, Humana told the buying public who bought the policy that it would pay 80% of all covered charges, the employee benefit booklet told the working person Humana Insurance would pay 80% of all covered charges, and the E.O.B. stated unequivocally that 80% of the covered charges were being paid; yet Humana Insurance secretly knew that it would get the vast majority of that money back. The differential between the true bill and the "fictitious" amount, i.e., the "kickback," is typically appropriated without any indication to the victim that a different payment arrangement or "discount" was involved.

Another indicator that this "discount" was really a kickback is the checking account arrangement Humana set up. I am informed that a so-called "zero balance" checking account was established by Humana Insurance to fund Mutual Administrator's account used to pay Sunrise Hospital the 80% of covered charges it was due pursuant to the policy.

A zero balance checking account will in fact reduce some of the lost "float" (lost use of the money) Humana Insurance would incur in actually paying 80% of the covered claims. However, Humana Insurance would still lose the use of its funds for some period of time while the checks made their way through the banking system.

From an economic standpoint, it makes no sense to pay 80% of a charge when you are responsible for only 11% of that charge. There appears to me no economic rationale for Humana's conduct of paying 80% of the Sunrise bill when it really knew it would be held responsible for only 11%, unless it was attempting to hide that fact from someone. This payment charade is further evidence to me that the "discount" was really a secret kickback.

Certain testimony of Humana employees further confirms that the "discount" was not a legitimate arms-length transaction, suggesting further that it was really a kickback that could be adjusted to whatever level was necessary for Humana's purposes.

The following is testimony from Samuel Hazen regarding the discounts provided by Humana Hospital to Humana Insurance. Mr. Hazen was employed at Humana Sunrise from August 1987 through May 1989 (Hazen Deposition at 11). Mr. Hazen testified as follows:

Q. All right. Now does this document indicate that in July of 1988 the total revenue for Humana Sunrise from patients insured by Humana Insurance was $426,140?

A. Yes.

Q. And does it indicate that there was a discount of $661,031?

A. Yes, this document indicates that.

Q. That was in July of 1988; is that correct?

A. Yes.

Q. Could you calculate for me what percentage of a discount that is, sir?

Q. I'll give you few moments if you wish. Would you like a pen?

A. I don't need a pen.

. . . .

Q. Are you calculating that in your head?

A. Yes. It's in excess of 150 percent. I don't have the exact amount.

Hazen Deposition at 39-40.

In my experience as an accountant for the hospital industry in the State of Nevada for 24 years, I have never seen a case where a hospital gave an 89%, or greater, discount off full billed charges. In 1989 the Nevada Department of Human Resources reported that the per diems charged to insurance companies by for-profit hospitals in Las Vegas other than Humana-Sunrise ranged from a low of $700 to a high of $950, far higher than the $125 per diem that Humana-Sunrise's 89% discount equalled. That large a discount would *not* seem to me, based on my experience in the industry, to be the result of an arm's-length negotiation. I would also agree with the testimony of Mr. Robert Lubbers wherein he stated:

Q. O.K. What about the number between July 1, 1987 and December 31, 1987, for renewing groups with a suggest -- or a stated discount or eighty-five point four percent; does that also shock you that it's that high?

A. After you see the first one, the second one says there's improvement and implies that some of the things the company would have done, you know, was achieving some of the goals.

Q. Well, it's the same time period, is it not? One is just for renewing groups and the other one for new business.

A. O.K. And once again I see you're starting to make assumptions, trying to help us out, and I shouldn't be.

Q. O.K. So, the ninety-six point four percent discount would be shocking, but the eighty-five point four percent would not be shocking?

A. Both the discounts shown on these papers are high, O.K., in my mind.

Lubbers Deposition, vol, II, at 247-48.

The fraudulent scheme perpetuated by Humana and Humana Insurance is further demonstrated by the fragrant inconsistencies between the amount of the discount that Humana Hospital reported to the State of Nevada in its quarterly reports and the amount of the discount that Humana Hospital later told the State of Nevada Insurance Division it had actually applied, as is set forth in greater detail above.

K. Humana Insurance Was Insolvent Without the Secret Discount.

I am of the opinion that Humana Insurance would not have been able to remain solvent but for the secret discount agreement. This is additionally evident from the fact that the discount increased dramatically in retroactive fashion in fiscal year end 1986. It appears from the financial reports that Humana Insurance realized that it was taking huge losses in 1986 and adjusted the discount in order to stay solvent. Larry Cash confirmed this in his deposition also. *See* § D *supra*.

I have reviewed the State of Nevada statutes regarding required reserves for insurance companies, and I am of the

opinion that without the secret discount being retroactively applied at 89%, Humana Insurance would have met the statutory definition of insolvency. This opinion is further supported by the rating of the National Association of Insurance Commissioners (NAIC) in 1986 of Humana Insurance, portions of which read as follows:

> A general overview analysis of ratio results and of the current year's and preceding year's Annual Statement has indicated that the company reported a net loss of $-1,969,501 and a decrease in capital and surplus from $1,432,039 to $358,697. The company's net income for the current year was reported as $-1,969,501 and included net investment income of $137,357. . . . In the opinion of the Examiner Team, this company should be accorded immediate regulatory attention based upon losses from current operation, adverse morbidity, low or worsening surplus and dependence upon surplus contribution. . . .

In her sworn deposition, Teresa Rankin, present Insurance Commissioner of Nevada, has stated:

Q Mrs. Rankin, was there a concern by the Insurance Division that Humana Helath Insurance of Nevada, Incorporated was in danger of insolvency?

A Yes there was. . . . I had met with some of our experts in the Division and also reviewed the annual statement from the prior year, so it would be year ending 12/31/85 for the domestic insurer, and according to my calculations they were about $8,000 above where they needed to be.

In other words, they were in danger of being statutorily impaired on their capital and surplus.

> In addition, their IRIS, which is the Insurancce Regulatory Information Service, that is what IRIS stands for, those regulations are produced by the National Association of Insurance Commissioners based on statutory accounting principles and five of their ratios were out of line and were not acceptable.

Rankin deposition at 24 (17) - 25 (11). The Laventhol & Horwath report stated at iv:

> The Insurance Company's operating losses for the period from 1984 through 1986 were $35,008 (1984), $1,969,501 (1985) and $2,811,737 (1986). . . . The inadequacy of the insurance premiums collected during the three year period from July, 1984 through February, 1987 are reflected in these operating losses. Furthermore, it appears that the Insurance Company would not have been solvent during this period of time except for capital contributions made by its affiliated "parent" company.

The testimony of David Gates, the Nevada Insurance Commissioner during 1986, also confirms that Humana Insurance was being scrutinized because of its financial condition. However, I understand that the Department of Insurance was not aware of the $15,000,000+ retroactive discount in 1986, and therefore Humana would have been under-capitalized or had insufficient reserves of an additional $15,000,000.00 or more than the reported amount, if the true financial picture had been presented to the State.

In addition to the high discount Humana Insurance received from Sunrise, I have also reviewed corporation minutes which indicate that the Group Health Division of Humana Inc. received additional capital contributions of a staggering $164,500,000.00 from June 1986 to June 1987.

I am also informed that approximately $11,000,000.00 of the contributed capital was provided to Humana Insurance in order to keep it statutorily solvent. These two factors -- the secret discount and the capital contributions -- in my opinion kept Humana Insurance from insolvency, thereby allowing it to continue to operate in Nevada. By continuing to operate Sunrise, Humana could continue to reap great economic benefits by reducing its stated profits in an era of legislative cost containment, even though, standing along, Humana Insurance appeared to be an economic disaster which would, by itself, not seem to justify further loss of investment.

This opinion is confirmed by testimony of Humana officials who state that the discount was an integral part of the management plan.

As the foregoing recitation of testimony demonstrates, the fundamental objective of the entire Humana Care Plus program was to divert patients to Humana Hospital, with the apparent understanding that it would cost the parent company substantial sums of money.

The former President of Humana Insurance Company stated that Humana Insurance would operate at a loss during its first three to five years (Werronen Deposition at 155-56). He further stated that Humana Insurance "had not anticipated operating at a profit at the outset" (*id.* at 163).

The fraud perpetrated through the "secret" discount has been described by Humana employees as being an "integral" part of the underlying hospital diversion scheme. The President of Humana Insurance in 1984 testified that the "secret" discount was an "integral part" of this management plan (Werronen Deposition at 78-79):

> Q. At some point later on, somebody developed an arrangement whereby Humana Hospital gave Humana insurance Company of Nevada a discount. Was that an

integral part of the management plan that you prepared for the executive committee -- Management Committee?

A. Yes.

He further stated that the "secret" discount was a fundamental concept of the Humana management plan (*id.* at 180, lines 1-12).

The President of Humana Insurance has testified that the contract with Humana Hospital Sunrise was not developed through normal negotiations because it was "an internal arrangement." (Werronen Deposition at 126, lines 15-21):

> The reason I draw that distinction is that the contract between Humana and whatever hospital we might have contracted with in Reno was a normal document. It was developed through rigorous negotiations and so forth. The arrangement with Humana Hospital Sunrise was an internal arrangement and wasn't nearly the same process. It was a different animal.

L. Humana's Consolidated Profits in Nevada Increased During the Class Period.

As stated in the preceding paragraph, although Humana Insurance may have lost money in Nevada, there appears to have been a significant benefit to the parent company in creating the insurance entity in spite of the losses it incurred.

I reviewed the quarterly financial reports submitted by Sunrise to the State of Nevada, along with certain other financial documents referred to in Section I. hereinabove, and based on that review concluded that Humana, Inc.'s consolidated profit derived from Nevada operations increased dramatically from 1985 to 1989, as set forth below:

HUMANA HOSPITAL AND INSURANCE
CONSOLIDATION PROFITS

	HOSPITAL	INSURANCE	CONSOLIDATED
1985 Base Yr.	18,374,580	(3,647,222)	14,727,358
1986	18,686,814	(4,648,437)	14,038,377
1987	28,184,000	(5,130,650)	23,053,350
1988	24,730,000	(851,950)	23,878,050
1989	34,869,000	(3,877,223)	30,991,777
TOTAL	106,469,814	(14,508,260)	91,961,554

This analysis clearly demonstrates that Humana's *combined* profits in Nevada continued to climb dramatically during the class period, belying the claim that Humana Insurance never made a profit and was passing large savings on to Nevada consumers, i.e., the class members. The fact is, Humana Insurance facilitated the consolidated entities' ability to dramatically increase their profits at the expense of Nevada citizens.

Humana's success at increasing its annual profits from 1985's $14,727,000.00 to 1989's $30,991,777.00, an increase of $16,264,777.00, is extremely impressive under any circumstances. To increase profits by the above amounts during a time of legislative cost containment is hard to believe.

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UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Motion for Leave to File Third Amended Complaint and Jury Demand. This Motion is based on Fed. R. Civ. P. 15, the pleadings and papers on file with the Court, and the points and authorities set forth herein.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying Defendants' Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

II

STATEMENT OF THE LAW

Fed. R. Civ. P. 15(a) allows a party to apply for leave to amend a pleading, and provides that "leave shall be freely given when justice so requires." One authority has observed that "[s]ubdivision (a) encourages the court to look favorably on requests to amend . . . . This proposition has been reinforced by innumerable judicial pronouncements by the federal appellate and district courts alike." 6 Charles A. Wright, Arthur R. Miller, & Mary K. Kane, *Federal Practice and Procedure* § 1483 (1990). Most significantly, the United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . the leave sought should, as the rules require, be "freely given."

Id., 371 U.S. at 182. *See also, e.g., United States v. Webb*, 655 F.2d 977 (9th Cir. 1981); *Hurn v. Retirement Fund Trust, Etc.*, 648 F.2d 1252 (9th Cir. 1981). In *Howey v. United States*, 481 F.2d 1187 (9th Cir. 1973), the Ninth Circuit reversed a denial of leave to amend, even five years after the initial complaint was filed, in the absence of prejudice to the defendant.

Plaintiffs' proposed Third Amended Complaint is additionally a supplemental pleading pursuant to Fed. R. Civ. P. 15(d). One of the reasons for the adoption of paragraph (d) is that otherwise a plaintiff might be forced into "commencing a new action even though events occurring after the commencement of the original action have made clear the right to relief." Fed. R. Civ. P. 15 advisory committee notes (1963). That is precisely the situation here.

III

ARGUMENT

1. Allegations regarding Defendants' RICO conspiracy.

Plaintiffs file this Third Amended Complaint to allege violations of 18 U.S.C.§ 1962(d), i.e., a conspiracy to violate 18 U.S.C. §§ 1962(a) and (c) of the federal RICO statutes. In its Order of July 9, 1991, this court dismissed a portion of Plaintiffs' RICO claims pursuant to 18 U.S.C. § 1962(a). The Court adopted the rule of some federal circuits that Plaintiffs were required to establish an injury by reason of the use or investment of racketeering income. The Court concluded that Plaintiffs "have not alleged injury resulting from investment of racketeering income, and could not do so even if they had the chance to amend." Order at 38.

On August 16, 1990, after Plaintiffs had filed both their initial Complaint and their first Amended Complaint, the Ninth Circuit issued an opinion in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991) that addressed the requirements for establishing a *conspiracy* to violate 18 U.S.C. 1962(a), pursuant to the conspiracy portion of the RICO statutes, 18 U.S.C. § 1962(d). The court held: "[A] plaintiff must have been injured by overt acts that are themselves statutorily defined acts of racketeering in order to have standing under § 1962(d)," *id.* at 295—i.e., by the predicate act itself, and not necessarily by the use or investment of racketeering income. In other words, the injury requirement for alleging a *conspiracy* to violate 18 U.S.C. § 1962(a), (b), or (c) leapfrogs those intermediate provisions and concentrates on the predicate act itself. Accordingly Plaintiffs now wish to amend their Complaint to allege that Defendants conspired to violate 18 U.S.C. § 1962(a) and (c).

2. Allegations regarding Wendell Cherry and William Larry Cash.

The proposed Third Amended Complaint additionally joins two culpable parties to this litigation: the estate of Wendell Cherry and its administrator, and William Larry Cash. Plaintiffs' grounds for joining those Defendants are set forth at length in the attached Third Amended Complaint 5-6 and *passim*.

3. Absence of prejudice to Defendants.

Granting Plaintiffs leave to file this Third Amended Complaint will not unduly prejudice defendants, for the following reasons:

—Plaintiffs allege no new operative facts. The same transactions, occurrences, relationships, and injuries that animated Plaintiffs' earlier complaints remain at the core of this Third Amended Complaint. Hence this litigation will not assume any essential new character by reason of the allegations set forth in this proposed Third Amended Complaint.

—The additional co-Defendants were knowing, willful, and active participants in the scheme to defraud. Hence they were aware of the transactions, occurrences, relationships, and injuries alleged in this litigation even long before Plaintiffs filed their initial Complaint. Moreover, those additional co-Defendants were aware of this litigation itself from the outset thereof and of Plaintiffs' allegations therein.

—The parties to this litigation have engaged in relatively few essential depositions. By far the larger portion of those essential depositions remain to be scheduled. Plaintiffs alone presently contemplate scheduling more than twenty-five depositions hereafter.

—More than three months remain in this litigation for discovery efforts and motions. That is entirely adequate for Defendants to pursue all necessary discovery activities.

III

CONCLUSION

For all of the foregoing reasons, Plaintiffs respectfully request leave to file a Third Amended Complaint and Jury Demand in conformance with Exhibit 1.

DATED this 31st day of October, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ Will Kemp
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ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this ___ day of October, 1991.

LIONEL SAWYER & COLLINS

By_____
LOUIS E. GARFINKEL, ESQ.
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Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 31st day of October, 1991, the foregoing PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

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UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

ORDER

The Court having considered the arguments of counsel, and good cause appearing, it is hereby

ORDERED, that Plaintiffs may file a Third Amended Complaint.

DATED this ___ day of _____, 1991.

_____
UNITED STATES DISTRICT COURT JUDGE

Submitted By:

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MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; ESTATE OF WENDELL CHERRY; FIRST KENTUCKY TRUST CO., in its capacity as administrator of the estate of WENDELL CHERRY; WILLIAM LARRY CASH; and DOES I through X, inclusive,

Defendants.

THIRD AMENDED COMPLAINT AND JURY DEMAND

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Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, J. Randall Jones and Will Kemp of Jones, Jones, Close & Brown, Chartered; Stanley M. Chesley of Waite, Schneider, Bayless & Chesley Co., L.P.A.; John L. Cummings III of Cummings, Cummings & Dudenhefer; and Wendell Gauthier of Gauthier & Murphy, for their causes of action against Defendants complain, aver, and allege as follows:

I

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, et seq., the Employment Retirement Income Security Act (''ERISA''); these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc. under Sections 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. §§ 1961 - 1968; these proceedings are also instituted under the law of the State of Nevada. Subject matter jurisdiction is conferred on this Court by 15 U.S.C. §§ 15 & 16, 18 U.S.C. § 1964(c), 28 U.S.C. § 1331, 28 U.S.C. § 1337, 28 U.S.C. § 1367, and 29 U.S.C. § 1132

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 18 U.S.C. § 1965, 28 U.S.C. § 1391, and 29 U.S.C. § 1132.

3. Defendants Humana and Humana Insurance maintain offices and transact business and may be found within the District of Nevada. The interstate trade and commerce

involved and affected by the alleged violations of the antitrust laws is carried on, in part, within the District of Nevada. These claims arose within the District of Nevada. It is in the ends of justice that other parties be brought before this Court.

II

RELEVANT TIMES

4. The period of time relevant to this Third Amended Complaint is from 1984 to the present. Within that relevant period, (a) the breaches of fiduciary duties by Defendants Humana Insurance, Wendell Cherry, and William Larry Cash continued from 1984 through at least 1989; (b) Defendants' monopolization or attempts to monopolize have continued from 1984 to the present; (c) Defendants' scheme to defraud and to obtain money by false pretenses continued from 1984 through at least 1989, (d) Defendants' pattern of racketeering activities have continued from 1984 to the present; and (e) the duration of each of the three enterprises described *infra* has continued from 1984 to the present. This Court has limited the period of recovery herein to that for Defendants' acts and events occurring during the period from 1985 through 1988, inclusive.

III

PARTIES

5. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant Humana Health Insurance of Nevada, Inc. (''Humana Insurance'') through payroll deductions.

6. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Mrs. Cade was at all times relevant Humana Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana Insurance policy. Robert Cade was hospitalized at Humana Hospital-Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

7. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and made premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through November 9, 1986. Pursuant to the 20% co-payment provisions, Ms. Andrews was obligated to pay and did pay a portion of all of her hospitalization costs.

8. Plaintiff Mary Lou Buehler, 210 Myers Avenue, Henderson, Nevada 89015, has been an insured with Humana Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in October of 1988, Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her charges for those hospitalizations were $23,293.94 and $2,736.85, respectively. Pursuant to the co-payment provision of her policy she was obligated to pay 20% of the costs of her hospitalization. Mrs. Buehler has paid a portion of the co-payment.

9. Plaintiff Helen Staves, HCR 65, Box 71408, Pahrump, Nevada 89041, has been insured with Humana Insurance since July 1988. At all times relevant, Ms. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital-Sunrise. Pursuant to the co-payment provisions under her policy, she was required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Ms. Staves paid her portion of the co-payment.

10. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987 Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital-Sunrise. At that time day surgery was performed on Mr. Bratton and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. (''Best Glass''), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has used Humana Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass's group number with Humana Insurance was 82801-18351-001. When Best Glass first became an insured with Humana Insurance, its premiums were very reasonable: $64.23 per employee per billing period. In 1986 those premiums increased by 3 percent, and in 1987 by 13 percent. Finally, in 1988, when Best Glass

decided not to renew with Humana Insurance, Humana Insurance sought a premium increase of 41 percent to continue coverage of employees of Best Glass.

12. Defendants did not inform individual Plaintiffs or Best Glass that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

13. Defendant Humana Health Insurance of Nevada, Inc. (''Humana Insurance'') is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana Insurance is a wholly-owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. (''Group Health''). Humana Insurance markets and sells group health insurance through employee benefit plans to employers throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona, and Utah.

14. Defendant Humana, Inc. (''Humana'') is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has been for many years, one of the largest owners and operators of acute-care hospitals in the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana Hospital-Sunrise (''Humana-Sunrise'') in Las Vegas, Nevada. Although Humana-Sunrise was only one of Humana's 87 hospitals in 1986, according to Humana's 1986 report to stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana Resources in 1986, Humana-Sunrise generated 38 percent of Humana's pretax profits.

15. Defendant Wendell Cherry was at all times relevant to this litigation a resident of Kentucky. Cherry was one of the two co-founders of Humana, Inc. During the years 1984 through 1989, Cherry was the President and Chief Operating Officer of Humana, Inc., a member of the Executive Committee of Humana, Inc., a director of both Humana, Inc. and Humana Insurance, and a principal stockholder of Humana, Inc. Cherry died on or about July 16, 1991. First Kentucky Trust Co. has been duly appointed as administrator of the estate of Wendell Cherry. Defendant William Cherry and Defendant First Kentucky Trust Co., in its capacity as the administrator of the estate of Wendell Cherry, are hereinafter referred to collectively as ''Wendell Cherry'' or ''Cherry.''

16. Defendant William Larry Cash is and was at all times relevant to this litigation a resident of Kentucky. Cash is and has been an employee of Humana, Inc. and/or Humana Insurance since at least 1973. During the period from 1983 through 1989 Cash held the position at first of Vice President of Finance and Controller, Group Health Division, Humana, Inc., and later of Senior Vice President of Finance, Group Health Division, Humana, Inc. From 1984 through at least 1989 Cash held the position of Vice President of Humana Insurance. From 1986 through at least 1989 Cash was a director of Humana insurance.

17. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOES I through X, inclusive, are not known to Plaintiffs at this time, who therefore sue those Defendants by fictitious names. Each of those Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will request leave to amend this Complaint to allege the true names and capacities of those Defendants when and as Plaintiffs ascertain them.

18. By order of this Court on September 26, 1989, Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade, Mary Lou Buehler, and Helen Staves (the "Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

19. By order of this Court on September 26, 1989, certain Plaintiffs (the "Antitrust Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

20. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves, and Best Glass (the "Antitrust Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

21. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Best Glass (the "RICO Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

22. By order of this Court on July 9, 1991, Plaintiffs Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, and Randolph Bratton (the "RICO Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

CLASS ACTION

IV

FIRST CLAIM FOR RELIEF

(Violations of ERISA)

23. The Co-Payor Class reasserts and realleges each and every allegation contained in paragraphs 1 through 22 of this Third Amended Complaint as though fully set forth at this point.

24. The Co-Payor Class consists of employees obtaining health insurance benefits under an employee benefit plan as defined under 29 U.S.C. 1001, et seq.

25. The members of the Co-Payor Class incurred charges at Humana-Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana Insurance was the insurer of the members of the Co-Payor Class through its group health insurance plan, Humana Care Plus.

A. Negotiation of the Secret Discount

26. On or about April 24, 1984, Humana and Humana Insurance negotiated a secret agreement that greatly reduced or discounted hospital charges for Humana Insurance patients incurring charges at Humana-Sunrise. Humana Insurance thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Humana Insurance was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

27. The aforementioned secret agreement between Humana and Humana Insurance specifically provided that

Humana-Sunrise agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services.

1. Involvement of Wendell Cherry.

28. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

29. Defendant Wendell Cherry was the President of Humana Insurance on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

30. Defendant Wendell Cherry was a director of Humana on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

31. Defendant Wendell Cherry was a director of Humana Insurance on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

32. Defendant Wendell Cherry was aware of the contents of the aforementioned secret agreement and of the provisions contained therein. Cherry authorized and approved those contents. Cherry thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Cherry was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

2. Involvement of William Larry Cash

33. Defendant William Larry Cash was a Vice President and the Controller of Humana on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

34. Defendant William Larry Cash was a Vice President of Humana Insurance on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

35. Defendant William Larry Cash was a signator to the aforementioned secret agreement, representing Humana Insurance, and therefore Cash was aware of the contents of that agreement. Accordingly Cash authorized and approved the contents of that agreement. Cash thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Cash was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

B. Concealment of the Secret Discount

36. During the years 1985 and 1986 Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of those insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

1. Involvement of Wendell Cherry

37. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

38. Defendant Wendell Cherry was a director of Humana during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

39. Defendant Wendell Cherry was a director of Humana Insurance during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or

discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

2. Involvement of William Larry Cash

40. Defendant William Larry Cash was a Vice President and the Controller of Humana during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

41. Defendant William Larry Cash was a Vice President of Humana Insurance during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

42. Defendant William Larry Cash was a director of Humana Insurance during the year 1986 when Humana

Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

C. Failure to Disclose the Secret Discount

43. During the years 1985 and 1986 Humana Insurance, Wendell Cherry, and William Larry Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

1. Involvement of Wendell Cherry

44. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the years 1985 and 1986 when Humana Insurance and Cherry failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower

than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

45. Defendant Wendell Cherry was a director of Humana during the years 1985 and 1986 when Humana Insurance and Cherry failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

46. Defendant Wendell Cherry was a director of Humana Insurance during the years 1985 and 1986 when Humana Insurance and Cherry failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

2. Involvement of William Larry Cash

47. Defendant William Larry Cash was a Vice President and the Controller of Humana during the years 1985 and 1986 when Humana Insurance and Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

48. Defendant William Larry Cash was a Vice President of Humana Insurance during the years 1985 and 1986 when Humana Insurance and Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

49. Defendant William Larry Cash was a director of Humana Insurance during the year 1986 when Humana Insurance and Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at

Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

D. Submission of the Fraudulent Master Policy

50. In 1984 Humana Insurance submitted for approval to the Insurance Division of Nevada a master policy of group health insurance. That master policy set forth terms, conditions, and representations that were to appear in all policies of group health insurance that Humana Insurance sought to market in Nevada, and was approved for that purpose by the Insurance Division of Nevada.

51. The aforementioned master policy, and the Humana Care Plus policies that conformed thereto, failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to those insureds the savings that Humana Insurance obtained by negotiating a discount on those charges.

52. The Humana Care Plus policies required that each member of the Co-Payor Class pay 20% of the charges for medical treatment at Humana-Sunrise. Humana Insurance agreed to pay the remaining 80% of those charges. The members of the Co-Payor Class believed, and their

agreements with Humana Insurance provided, that the members of the Co-Payor Class and Humana Insurance would be paying their respective contractual percentages of the charges.

1. Involvement of Wendell Cherry

53. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

54. Defendant Wendell Cherry was the President of Humana Insurance in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

55. Defendant Wendell Cherry was a director of Humana in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

56. Defendant Wendell Cherry was a director of Humana Insurance in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

57. Defendant Wendell Cherry was a signator to the aforementioned master policy, and therefore Cherry was aware of the contents of that master policy and of the Humana Care Plus policies that conformed thereto. Accordingly Cherry authorized and approved the contents of that master policy and of the Humana Health Plus policies that conformed thereto.

2. Involvement of William Larry Cash

58. Defendant William Larry Cash was a Vice President and the Controller of Humana in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

59. Defendant William Larry Cash was a Vice President of Humana Insurance in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

E. Sale of the Fraudulent Group Policies

60. During the period from 1984 through 1988 Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

1. Involvement of Wendell Cherry

61. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

62. Defendant Wendell Cherry was President of Humana Insurance during a portion of the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

63. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

64. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

2. Involvement of William Larry Cash

65. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana

during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

66. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

67. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

68. Defendant William Larry Cash was a signator, on behalf of Humana Insurance, to some or all of the Humana Care Plus policies that contained the same terms, conditions, and representations as those set forth in the aforementioned master policy, and therefore Cash was aware of the contents of that master policy and of the Humana Care Plus policies that conformed thereto. Accordingly Cash authorized and approved the contents of those Humana Care Plus policies.

F. Promotion of the Fraudulent Group Policies

69. Humana Insurance advertised its policies of group health insurance during the period from 1984 through 1988 and stated in those advertisements that Humana Insurance had reduced the costs of providing medical treatment and was passing along those savings to its insureds. In those advertisements Humana Insurance did not inform insureds that Humana Insurance was not passing along to them the savings it obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

70. Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to

them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

1. Involvement of Wendell Cherry

71. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

72. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

73. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

74. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

2. Involvement of William Larry Cash

75. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

76. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

77. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

G. Failure to Pass Along Reduced Costs or Discounts

78. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 in they failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

1. Involvement of Wendell Cherry

79. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

80. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

81. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

82. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

2. Involvement of William Larry Cash

83. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana

during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

84. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

85. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

H. Failure to Accomplish Exclusive Purpose of Providing Benefits and Defraying Costs of Administration

86. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana Insurance imprudently decided to retain the co-payment refunds that Humana Insurance negotiated with Humana. Humana Insurance received excessive compensation in violation of its fiduciary duties pursuant to 29 U.S.C. § 1104.

1. Involvement of Wendell Cherry

87. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

88. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

89. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

90. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

2. Involvement of William Larry Cash

91. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

92. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

93. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

I. Failure to Adhere to Documents and Instruments Governing the Plan

94. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and 289, and 29 U.S.C. § 1104.

1. Involvement of Wendell Cherry

95. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

96. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

97. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

98. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

2. Involvement of William Larry Cash

99. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash

breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

100. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

101. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104

J. Failure to Discharge Duties With Diligence and Care

102. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use the conduct of an enterprise of a like character and with like aims.

1. Involvement of Wendell Cherry

103. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary

duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

104. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

105. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

106. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

2. Involvement of William Larry Cash

107. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would have used in the conduct of an enterprise of a like character and with like aims.

108. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would have used in the conduct of an enterprise of a like character and with like aims.

109. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would have used in the conduct of an enterprise of a like character and with like aims.

K. Dealing in a Fiduciary's Self-Interest

110. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash engaged in prohibited transactions in violation of their fiduciary duties during the period from

1984 through 1988 by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

1. Involvement of Wendell Cherry

111. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

112. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

113. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

114. Defendant Wendell Cherry was a director of Humana insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

2. Involvement of William Larry Cash

115. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

116. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

117. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

L. Acting on Behalf of an Adverse Party

118. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash engaged in prohibited transactions in violation of their fiduciary duties during the period from 1984 through 1988 by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

1. Involvement of Wendell Cherry

119. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from

1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

120. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

121. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

122. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

2. Involvement of William Larry Cash

123. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cash was prohibited from even negotiating the co-payment amount with Humana Insurance's related entity Humana, in violation of 29 U.S.C. § 1106.

124. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cash was prohibited from even negotiating the co-payment amount with Humana Insurance's related entity Humana, in violation of 29 U.S.C. § 1106.

125. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cash was prohibited from even negotiating the co-payment amount with Humana Insurance's related entity Humana, in violation of 29 U.S.C. § 1106.

M. Receiving Consideration for a Fiduciary's Own Account

126. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash engaged in prohibited transactions in violation of their fiduciary duties during the period from

1984 through 1988 by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

1. Involvement of Wendell Cherry

127. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

128. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

129. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

130. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

2. Involvement of William Larry Cash

131. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

132. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

133. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

N. Requested Relief

134. It would be wrongful for Humana Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of the duties of Humana Insurance, Wendell Cherry, and William Larry Cash to the Co-Payor Class and of Human Insurance's agreement with the Co-Payor Class.

135. A constructive trust should be imposed on Defendants that requires surrender of all monies obtained through the scheme described herein.

136. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

137. As a result of Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit on Defendant Humana Insurance. Defendant Humana Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of the scheme, Defendant Humana Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

138. The acts and practices of Defendants as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana Insurance.

139. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana Insurance, Wendell Cherry, and William Larry Cash, and it is estimated that the approximate actual damages are in excess of $84,520,143.00.

140. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

V

SECOND CLAIM FOR RELIEF

(Violations of Federal Antitrust Laws)

141. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 140 of this Third Amended Complaint as though fully set forth at this point.

142. The Antitrust Premium-Payer Class consists of individuals or entities paying all or a portion of the Humana Insurance premiums during the period from 1985 through 1988, including without limitation employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

143. Defendant Humana is in the business of owning and operating for-profit acute-care health facilities. Humana owns and operates a for-profit acute-care health care facility named Humana Hospital-Sunrise which provides hospital services in Las Vegas, Nevada.

144. Defendant Humana is also in the business of owning and operating group health care insurance companies, and in 1984 established one such company, Humana Insurance, with its principal place of business in Nevada.

145. The relevant geographic market for antitrust purposes is Clark County, Nevada or a portion thereof.

146. The relevant product market affected by Defendants' conduct is the sale of general, non-specialty, for-profit, acute-care hospital services or a portion thereof, and the group health insurance or health care financing market or a portion thereof.

147. Humana-Sunrise has possessed and exercised market power in the relevant geographic market during the class period. One indication of Humana-Sunrise's market power is its ability consistently to generate profit levels far above competitive levels found in comparable geographic markets, or as compared to national averages, or as compared to Humana hospitals located in other states. In addition to exercising this power within the market for the sale of general, non-specialty, for-profit, acute-care hospital services, the market power of Humana-Sunrise is heightened within relevant submarkets that may include only privately-owned hospitals, or other submarkets that focus on particular hospital products or services, especially as those products or services are obtained by private insureds.

148. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing and attempting to monopolize the above-described markets and/or submarkets.

149. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendants formed a symbiotic relationship between Humana-Sunrise and Humana Insurance, with Humana Insurance acting as a feeder mechanism to funnel Humana Insurance insureds into Humana-Sunrise, where those insureds became members of the Antitrust Co-Payor Class. Defendants established and maintained that relationship with the express purpose and effect of maintaining or enhancing the market power of Humana-Sunrise.

150. Humana and Humana Insurance engaged in a scheme that consisted of numerous actions, the primary purpose and effect of which was to maintain or enhance the market power of Humana-Sunrise.

151. As part of the aforementioned scheme, Humana-Sunrise Hospital and Humana Insurance entered into a secret discount arrangement. Humana and Humana Insurance did not offer that discount arrangement to other insurance companies or to other general, non-specialty, for-profit, acute-care hospitals in the relevant geographic market, did not include Humana Insurance co-payers in that discount arrangement, and did not pass along to Humana Insurance co-payors the savings that Humana Insurance obtained from that discount arrangement. That discount arrangement additionally allowed Humana-Sunrise to conceal illegal profits.

152. As part of the aforementioned scheme, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred an unfair competitive advantage on Defendants.

153. As part of the aforementioned scheme, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

154. As part of the aforementioned scheme, Humana and Humana Insurance hospital engaged in additional actions, including without limitation the following:

A. Defendants promoted the use of services offered by Humana-Sunrise and discouraged the use of services offered by other general, non-specialty, for-profit, acute-care hospitals through Humana Insurance policies, by requiring extensive penalties for insureds who obtained services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise. Those penalties included without limitation the following:

1. Requiring a different and punitive deductible for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

2. Requiring a different and punitive co-payment for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

3. Applying a different standard of review when evaluating and paying claims from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise.

B. Humana engaged in a pattern of predatory pricing by offering Humana Insurance an unreasonable discount, while not offering that discount to other group health insurers in the relevant geographic market, nor to members of the Antitrust Co-Payor Class;

C. Humana Insurance required premiums for group health insurance policies that were anti-competitively high in comparison to premiums charged for compara-

ble insurance by other group health care insurers in comparable geographic markets;

D. Humana Insurance initially engaged in predatory pricing within the relevant geographic market by attempting to undercut the premiums required for comparable insurance by other group health insurers in that market.

E. Humana Insurance required premiums for group health insurance policies that were far higher than those that normal actuarial practices would have indicated were reasonable for the percentages and amounts of co-payments of Humana-Sunrise's actual charges that members of the Antitrust Co-Payor Class paid.

155. The aforementioned scheme created misinformation among employers, insureds, and other third-party payers regarding hospital per diem arrangements and maximum potential discounts, thereby blunting competitive forces and allowing Humana-Sunrise to charge higher prices and offer less discounts than it could have without the scheme. In addition, because Humana Insurance misrepresented the risk-sharing provisions of its group health insurance plan, the premiums that Humana Insurance charged were artificially high, notwithstanding that at times those premiums may have been priced nominally lower than the premiums of comparable policies within the Clark County, Nevada area.

156. As a direct and proximate result of Defendants' market position and power, of their specific intent to maintain or enhance that market power, and of their actions to maintain or enhance that market power with a dangerous probability of success, the members of both the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class incurred antitrust injuries and damages. The members of the Antitrust Premium-Payor Class incurred antitrust injuries and damages in that they were required to pay premiums for

Humana Insurance policies that were high in comparison to what competitive rates would have been in the absence of Humana's market power. The members of the Antitrust Co-Payor Class incurred antitrust injuries and damages in that they were required to pay co-payments for Humana-Sunrise services that were high in comparison to what competitive rates would have been in the absence of Humana's market power.

157. Plaintiffs estimate that the approximate actual damages of the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class are in excess of $181,034,570.00, the principal of which is subject to trebling.

158. The anticompetitive acts and practices of Humana and Humana Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

VI

THIRD CLAIM FOR RELIEF

(Violations of Federal Racketeering Laws)

A. General Allegations

159. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 158 of this Third Amended Complaint as though fully set forth at this point.

160. Each Plaintiff and each member of the designated class that Plaintiffs represent is a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

161. With respect to their activities alleged herein, Defendants acted at all times with malice, intent, and knowledge, and with a wanton and reckless disregard for the rights of Plaintiffs.

162. With respect to the activities alleged herein, each Defendant aided and abetted each other Defendant, and others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of 18 U.S.C. § 2. Each Defendant agreed to the operation of the scheme to defraud and to obtain money by false pretenses.

163. With respect to the activities alleged herein, other than those involving violations of 18 U.S.C. 1962(d), each Defendant conspired with each other Defendant, and with others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of 18 U.S.C. § 1962(d). Each Defendant agreed to the conspiracy to defraud and to obtain money by false pretenses.

164. As part of a scheme to defraud Plaintiffs and to obtain money from Plaintiffs by false pretenses, by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana Insurance entered into a secret agreement (the "Agreement") whereby Humana-Sunrise agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and whereby Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services. Humana Insurance did not discount the portion of those charges paid by Plaintiffs but based them instead on the usual and customary rate.

165. Humana Insurance did not reduce premiums in the amount discounted. As a part of the scheme to defraud and to obtain money by false pretenses, Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash used false and fraudulent pretenses, representations, and promises

calculated to deceive persons of ordinary prudence and due care, and concealed and made material nondisclosures of facts and information important to the insureds, including without limitation the existence of the secret agreement and that Humana was billing Humana Insurance at a different per diem, all so as to unlawfully, intentionally, and willfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed. R. Civ. P. 23.

166. The scheme to defraud and to obtain money by false pretenses evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which Humana and Humana Insurance carried out their broad objectives consisted of a complex pattern of individual transactions and group transactions.

167. As part of the scheme to defraud and to obtain money by false pretenses, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

168. As a part of the scheme to defraud and to obtain money by false pretenses, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, false, misleading, and fraudulent advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment

in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants.

B. Racketeering Activities

169. In carrying out the scheme to defraud and to obtain money by false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash engaged in, *inter alia*, conduct in violation of federal laws, viz., 18 U.S.C. § 1341, 18 U.S.C. § 1343, and 18 U.S.C. § 1503, as stated below:

1. 18 U.S.C. § 1341.

170. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false or fraudulent pretenses, representations, or promises, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash placed in post offices, and/or in authorized repositories for mail matter, matters and things to be sent or delivered by the Postal Service, and received matters and things therefrom, and knowingly caused to be delivered by mail those matters and things according to the directions thereon or at the place at which they were directed to be delivered by the persons to whom they were addressed, including without limitation as set forth in Appendix 1.

(1) In those matters and things Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Humana and/or Humana Insurance intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations.

(2) In those matters and things Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

Each such use of the mail during and in furtherance of the scheme to defraud and to obtain money by false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1341.

2. 18 U.S.C. § 1343.

171. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false pretenses, representations, and promises, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash transmitted or caused to be transmitted in interstate commerce wire, radio, and television transmissions, including without limitation as set forth in Appendix 2.

A. Defendants sent, or caused to be sent, interstate radio and television advertisements promoting the Humana Insurance group health insurance plan. Those radio and television advertisements were broadcast from locations in Nevada across state borders to persons located in Arizona and/or Utah. In those advertisements Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash never disclosed to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain in the form, inter alia, of a fraudulently unfair competitive advantage. The insureds reasonably relied on those nondisclosures.

B. Defendants used the interstate telephone lines to explain or discuss billings in order to collect co-payments from insureds for hospital charges incurred at Humana-Sunrise. Defendants maintained offices both in Las Vegas, Nevada and in Louisville, Kentucky. Defendants engaged in telephone conversations from their Nevada offices with Plaintiffs located in other states, including without limitation Arizona, California, and Utah, and from their Kentucky offices with Plaintiffs located in other states, including without limitation Arizona, California, Nevada, and Utah. In those telephone conversations Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing

along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

C. On or about December 1, 1987, Defendants established a Louisville Claims Center in Louisville, Kentucky and a toll-free telephone line to that office for the specific purpose of handling claims from corporate Plaintiffs located in Nevada. Defendants engaged in telephone conversations from their Kentucky offices with corporate Plaintiffs located in Nevada. In those telephone conversations Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

D. Defendants engaged in telephone conversations from their offices in Louisville, Kentucky with persons in Nevada in the offices of the government of the State of Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses.

E. Defendants have certified that during the period from 1984 through 1988, they engaged in an estimated 14,000,000 interstate telephone conversations. Those telephone conversations were in support of the scheme to defraud and to obtain money by false pretenses.

F. Humana, Inc. and/or Humana Insurance transferred millions of dollars by wire transfer from Nevada to other states and from other states to Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses, including without limitation as set forth in Appendix 2. Those interstate transfers of funds were in support of the scheme to defraud and to obtain money by false pretenses.

Each such use of interstate wire transmissions during and in furtherance of the scheme to defraud and to obtain money by means of false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1343.

3. 18 U.S.C. § 1503.

172. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, including without limitation:

A. Humana and Humana Insurance (hereinafter referred to as "corporate Defendants") concealed from Plaintiffs 930 boxes or mroe of documents relevant to this litigation. Corporate Defendants' concealment of those 930 or more boxes of documents resulted in the improper suppression of evidence. Corporate Defendants concealed those 930 boxes or more of documents by multiple acts and omissions, including without limitation:

1. Corporate Defendants signed and served on Plaintiffs false responses to requests for production that Plaintiffs had issued to Defendants. In those responses Corporate Defendants failed to inform Plaintiffs of the aforementioned 930 boxes or more of documents that were responsive to Plaintiffs' requests, and Corporate Defendants failed to produce those 930 boxes or more of documents.

2. On or about August 30, 1991, Corporate Defendants falsely testified, in the sworn deposition of Corporate Defendants' counsel John Andris, that Corporate Defendants possessed none of the written documents contained in the aforementioned 930 boxes or more.

3. On or about September 4, 1991, Corporate Defendants falsely informed Plaintiffs that the only way to obtain the information that was in fact

contained in the aforementioned 930 boxes or more of documents was by retrieving it from computer records at a cost of $200,000 to Plaintiffs.

Corporate Defendants in fact knew they were in possession of those 930 boxes or more of documents and that those documents were responsive to Plaintiffs' requests for production. Corporate Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Corporate Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice;

B. On or about January 18, 1990, Corporate Defendants signed, filed with this Court, and served on Plaintiffs a Second Motion to Dismiss, and on or about April 10, 1990, Corporate Defendants signed, filed with this Court, and served on Plaintiffs a Reply to Plaintiffs' Opposition thereto, wherein Corporate Defendants falsely indicated they had not engaged in interstate wire communications. Corporate Defendants in fact knew they had engaged in more than 14,000,000 interstate telephone communications and numerous interstate wire transfers of funds. Corporate Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Corporate Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice.

C. On or about August 30, 1991, Corporate Defendants falsely testified, in the sworn deposition of Corporate Defendants' Director of Underwriting, James W. Keene, that Corporate Defendants had never maintained a "Jeopardy Committee." Keene in fact knew that Corporate Defendants had maintained a Jeopardy Committee over a period of several years, that he had

routinely communicated with members of that committee, and that the committee had generated numerous documents and records. The significance of Corporate Defendants' Jeopardy Committee is that it was authorized to reduce premiums for group health insurance below the levels dictated by normal actuarial principles, and in flagrant disregard of the rating methodology that Humana Insurance represented to the Insurance Division of Nevada as determining the premiums that Humana Insurance charged. The intervention of the Jeopardy Committee thereby allowed Humana Insurance to sell or renew policies of group health insurance that Humana Insurance was otherwise in jeopardy of not selling or renewing. In addition, the intervention allowed Humana Insurance to set premiums so low that Humana Insurance operated at a loss, in violation of Nevada insurance regulations.

Each such act or omission to corruptly influence, obstruct, and impede, or endeavor to influence, obstruct, and impede, the due administration of justice violated 18 U.S.C. § 2 and 18 U.S.C. § 1503.

173. At all times when Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, this litigation was a pending judicial proceeding, and consequently this Court was engaged in the due administration of justice.

C. The RICO "Enterprise"

174. Plaintiffs allege three alternative "enterprises" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c), and, with respect to each of those alternatives, an alternative "person" or "persons" within the meaning of

18 U.S.C. § 1961(3), § 1962(a), and § 1964(c), as set forth below.

175. Each enterprise was engaged in interstate commerce during the relevant times, and the activities of each enterprise affected interstate commerce during those times. Defendants provided medical services, and group health insurance for medical services, to persons who were residents of states other than Nevada. In furtherance of their business activities, Defendants contracted with and purchased from vendors located in states other than Nevada equipment and supplies that were delivered to Defendants' offices in Nevada from those other states by means of interstate transportation. In furtherance of their business activities, Defendants used the United States mails and interstate telephone and wire communications.

1. Humana as RICO "Enterprise" but not as RICO "Person"

176. Humana was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

177. Each of Defendants Humana Insurance, Wendell Cherry, and William Larry Cash, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

2. Humana Insurance as RICO "Enterprise" but not as RICO "Person"

178. Humana Insurance was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

179. Each of Defendants Humana, Wendell Cherry, and William Larry Cash Humana, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

3. The "Humana Group" as RICO "Enterprise"

180. Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance were members of an association-in-fact, hereinafter referred to as the "Humana Group," that constituted an "enterprise" within the meaning of 19 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

181. Each of Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

182. The Humana Group shared common purposes, exhibited distinct divisions of responsibility, existed independently of the pattern of racketeering activity, and continued as an economic unit with the same members at its core during the period from 1984 through 1988.

a. Membership of the Humana Group

183. The Humana Group included, along with Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash, the officers and directors of Humana and Humana Insurance, all companies that prepared and/or disseminated advertising for Humana and/or Humana Insurance, and all sales brokers who sold policies of group health insurance issued by Humana Insurance.

b. Purposes and Responsibilities of the Humana Group.

184. The general purposes of the Humana Group were to provide medical services by Humana-Sunrise and insurance for medical services by Humana-Sunrise.

185. The specific purposes and responsibilities of Defendants Humana, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana, included without limitation providing medical services by Humana-Sunrise.

186. The specific purposes and responsibilities of Defendants Humana Insurance, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana Insurance, included without limitation providing insurance for medical services by Humana-Sunrise.

187. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana included without limitation promoting the sale of medical services by Humana-Sunrise.

188. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana Insurance and of sales brokers included without limitation promoting the sale of insurance for medical services by Humana-Sunrise.

c. Bases for the Humana Group

189. The bases for the association between and among Defendants Humana, Wendell Cherry, William Larry Cash, and the officers and directors of Humana included without limitation the articles of incorporation and bylaws of the firm.

190. The bases for the association between and among Defendants Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana Insurance included without limitation the articles of incorporation and bylaws of the firm.

191. The bases for the association between Defendants Humana and Humana Insurance included without limitation the contractual preferred-provider agreements they entered into with each other.

192. The bases for the association between and among Defendant Humana and companies that prepared and/or disseminated advertising for Humana included without limi-

tation contractual agreements that Humana entered into with each of them.

193. The bases for the association between and among Defendant Humana Insurance and companies that prepared and/or disseminated advertising for Humana Insurance included without limitation contractual agreements that Humana Insurance entered into with each of them.

194. The bases for the association between and among Defendant Humana Insurance and sales brokers included without limitation contractual agreements that Humana Insurance entered into with each of them.

d. Time Period of the Humana Group

195. The Humana Group was intended to continue for an indefinite period of time. It has in fact continued from 1984 to the date of filing of this Third Amended Complaint.

e. Culpability of the Humana Group

196. The only members of the Humana Group that were aware of all or a portion of the scheme to defraud and to obtain money by means of false pretenses were Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance.

D. Violations of 18 U.S.C.§ 1962(c)

197. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, the conduct of the affairs of that enterprise through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

198. Each Defendant, other than when it was the enterprise, aided and abetted each other Defendant, and persons not presently known to Plaintiffs, in committing the aforementioned violations of 18 U.S.C. 1962(c), all in violation of 18 U.S.C. § 2.

199. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

E. Violations of 18 U.S.C. 1962(d) conspiracy to violate 18 U.S.C. § 1962(a)

200. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(a) by using or investing, directly or indirectly, in the acquisition of any interest, income, or the establishment or operation of one of the alternative enterprises, part of income derived, directly or indirectly, from a pattern of racketeering activity viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

201. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to

obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(a).

F. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(c)

1. Conduct or participation in the affairs of the enterprise

202. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly, in the conduct of the affairs of one of the alternative enterprises through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

203. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

2. Conduct or participation in a pattern of racketeering activity.

204. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly,

through the conduct of the affairs of one of the alternative enterprises, in a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

205. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

G. Requested Relief

206. By reason of the violations of 18 U.S.C. § 2 and § 1962(c) and (d) committed by Defendants, it is estimated that the actual damages of the RICO class are in excess of $181,034,570.00, the principal of which is subject to trebling.

207. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

VII

FOURTH CLAIM FOR RELIEF

(Violations of Nevada Racketeering Laws)

A. General Allegations

208. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 207 of this Third Amended Complaint as though fully set forth at this point.

209. Each Plaintiff and each member of the designated class that Plaintiffs represent is a "person who is injured in his business or property by reason of any violation of NRS 207.400" within the meaning of Nev. Rev. Stat. § 207. 470(1).

210. With respect to their activities alleged herein, Defendants acted at all times with malice, intent, and knowledge, and with a wanton and reckless disregard for the rights of Plaintiffs.

211. With respect to the activities alleged herein, each Defendant aided and abetted each other Defendant, and others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of Nev. Rev. Stat. § 195.020. Each Defendant agreed to the operation of the scheme to defraud and to obtain money by false pretenses.

212. With respect to the activities alleged herein, other than those involving violations of Nev. Rev. Stat. § 207. 400(h), each Defendant conspired with each other Defendant, and with others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of Nev. Rev. Stat. § 207.400(1)(h). Each Defendant agreed to the conspiracy to defraud and to obtain money by false pretenses.

213. As part of a scheme to defraud Plaintiffs and to obtain money from Plaintiffs by false pretenses, by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana Insurance entered into a secret agreement (the "Agreement"). Pursuant to the Agreement, Humana Insurance agreed to pay Humana-Sunrise a discounted amount for that portion of the hospital charges for which it was responsible. The portion of the charges paid by others, however, was not discounted but was still based on the usual and customary rate.

214. Humana Insurance did not reduce premiums in the amount discounted. It was part of the scheme to defraud and to obtain money by false pretenses that Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash used false and fraudulent pretenses, representations and promises calculated to deceive persons of ordinary prudence and due care and made material nondisclosures and concealment of fact and information important to the insureds, including without limitation the existence of the secret agreement and that Humana was billing Humana Insurance at a different per diem, all so as to unlawfully, intentionally, and willfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed. R. Civ. P. 23.

215. The scheme to defraud and to obtain money by false pretenses evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which the broad objectives of Humana and Humana Insurance were

carried out consisted of a complex pattern of individual transactions and group transactions.

216. As part of the scheme to defraud and to obtain money by false pretenses, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

217. As a part of the scheme to defraud and to obtain money by false pretenses, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, false, misleading, and fraudulent advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants.

B. Racketeering Activities

218. In carrying out the scheme to defraud and to obtain money by false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash engaged in, *inter alia*, conduct in violation of Nevada law, viz., Nev. Rev. Stat. § 205.380, § 686a.291(1), § 686A.291(2), and § 686A.291(3), as stated below:

1. Nev. Rev. Stat. § 205.380.

219. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Wendell Cherry, and/or William Larry Cash Humana obtained money in an amount in excess of $100, in the form of premiums and co-payments from Plaintiffs, by knowingly and designedly, and with intent to cheat and defraud Plaintiffs, making false and fraudulent representations thereto and by falsely and fraudulently failing to disclose information material to transactions therewith.

220. The false and fraudulent representations were that Humana Insurance would pay 80% of the charges, beyond the deductible, incurred by insured employees for medical treatment at Humana-Sunrise. The information material to transactions with Plaintiffs that Defendants falsely and fraudulently failed to disclose to insureds was that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

A. Defendants made those misrepresentations, and failed to disclose that information, orally and in written form to employers who were to pay all of a portion of the premiums for group health insurance issued by Humana Insurance. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to employers for the purpose of deceiving

them and thereby obtaining financial gain. Those employers reasonably relied on the misrepresentations and failures to disclose in deciding to purchase group health insurance issued by Humana Insurance. Consequently those employers grossly overpaid for group health insurance issued by Humana Insurance.

B. Defendants made those misrepresentations, and failed to disclose that information, orally and in written form to employees who were to pay all or a portion of premiums for group health insurance issued by Humana Insurance. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to employers for the purpose of deceiving them and thereby obtaining financial gain. Those employees reasonably relied on the misrepresentations and failures to disclose in deciding to participate in and pay all or a portion of the premiums for group health insurance issued by Humana Insurance. Consequently those employees grossly overpaid for group health insurance issued by Humana Insurance.

C. Defendants made those misrepresentations, and failed to disclose that information, orally and in written form to employees who were thereafter insured by group health insurance issued by Humana Insurance and who obtained medical treatment at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to employees for the purpose of deceiving them and thereby obtaining financial gain. Those employees reasonably relied on the misrepresentations and failures to disclose in deciding to obtain medical treatment at Humana-Sunrise. Consequently those employees grossly overpaid for medical treatment they received at Humana-Sunrise.

D. Defendants made those misrepresentations, and failed to disclose that information, in bills and statements of charges that Humana-Sunrise sent to insureds that falsely and fraudulently represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, and that falsely and fraudulently failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. Those insureds reasonably relied on those misinterpretations and failures to disclose. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

E. Defendants made those representations, and failed to disclose that information, in explanations of benefits that Humana Insurance sent to insureds that falsely and fraudulently represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, and that falsely and fraudulently failed to

disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those failures to disclose. Additionally, those explanations of benefits falsely and fraudulently represented that Humana Insurance had paid or would pay percentages and/or dollar portions of those charges that Humana Insurance in fact had not paid and would not pay. The insureds reasonably relied on those misrepresentations. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

2. Nev. Rev. Stat. § 686A.291(1).

221. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Wendell Cherry, and/or William Larry Cash knowingly and willfully presented or caused to be presented to Humana Insurance false, incomplete, and misleading information concerning a material fact, as a part of and in support of claims for payment or reimbursement.

222. The false, incomplete, and misleading information was the amounts that Humana charged for medical treatment, at Humana-Sunrise, of persons insured by Humana Insurance. That information was false, incomplete, and misleading in that it failed to disclose that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information.

223. Humana presented or caused to be presented to Humana Insurance that information both in written form and by electronic data transmission as claims for payment or reimbursement of Humana by Humana Insurance for medical treatment at Humana-Sunrise of persons insured by Humana Insurance, as operations statistics reports, and as month-end reports.

3. Nev. Rev. Stat. § 686A.291(2).

224. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, false, incomplete, and misleading information, both written and oral, concerning material facts as part of and in support of claims for payments, reimbursements and other benefits.

225. The false information was that Humana Insurance would pay 80% of the charges, beyond the deductible, incurred by insured employees for medical treatment at

Humana-Sunrise. Additionally, that information was incomplete and misleading in that it failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those failures to disclose.

A. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information orally and in written form to employers who were to pay all of a portion of the premiums for group health insurance issued by Humana Insurance. Those employers reasonably relied on the information in deciding to purchase group health insurance issued by Humana Insurance. Consequently those employers grossly overpaid for group health insurance issued by Humana Insurance.

B. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information orally and in written form to employees who were to pay all or a portion of premiums for group health insurance issued by Humana Insurance. Those employees reasonably relied on the information in deciding to participate in and pay all or a portion of the premiums for group

health insurance issued by Humana Insurance. Consequently those employees grossly overpaid for group health insurance issued by Humana Insurance.

C. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information orally and in written form to employees who were thereafter insured by group health insurance issued by Humana Insurance and who obtained medical treatment at Humana-Sunrise. Those employees reasonably relied on the information in deciding to obtain medical treatment at Humana-Sunrise. Consequently those employees grossly overpaid for medical treatment they received at Humana-Sunrise.

D. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information in bills and statements of charges that Humana-Sunrise sent to insureds that falsely, incompletely, and misleadingly represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, that falsely, incompletely, and misleadingly failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those insureds reasonably

relied on that information and those failures to disclose. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

E. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information in explanations of benefits that Humana Insurance sent to insureds that falsely, incompletely, and misleadingly represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, and that falsely, incompletely, and misleadingly failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those insureds reasonably relied on the information and failures to disclose. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

4. Nev. Rev. Stat.§ 686A.291(3).

226. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash concealed from and failed to disclose to Plaintiffs events affecting the initial and continued right of Plaintiffs to benefits and payments to which Plaintiffs were entitled.

227. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash concealed from and failed to disclose to Plaintiffs that Defendants Humana and Humana Insurance had entered, at varying times, into an agreement and amendments thereto whereby Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and whereby Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services. Humana Insurance did not pass along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to Plaintiffs for the purpose of deceiving them and thereby obtaining financial gain. Plaintiffs reasonably relied on those failures to disclose.

228. The agreement and amendments thereto affected the initial and continued right of Plaintiffs to benefits, in that the agreement and amendments thereto should have reduced or discounted, but did not, the amount of charges, beyond the deductible, for medical treatment incurred at Humana-Sunrise with respect to which Plaintiffs were obligated to pay 20%.

229. The agreement and amendments thereto affected the initial and continued right of Plaintiffs to payments by Humana Insurance, in that the agreement and amendments thereto should have provided, but did not, that Humana Insurance would pay 80% of the charges that Humana-Sunrise agreed to accept as payment in full for medical treatment incurred by Plaintiffs. Plaintiffs were entitled to those 80% payments, in that Plaintiffs were the beneficiaries

of contracts entered into by Humana Insurance whereby Humana Insurance was obligated to pay that 80%.

230. The agreement and amendments thereto affected the initial and continued right of Plaintiffs to benefits, in that the agreement and amendments thereto should have provided, but did not, for Humana Insurance to pass along to its insureds the savings that Humana Insurance obtained by negotiating a discount on those charges.

C. The RICO "Enterprise"

231. Plaintiffs allege three alternative "enterprises" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c), and, with respect to each of those alternatives, an alternative "person" or "persons" within the meaning of Nev. Rev. Stat. § 207.400(1), § 205.380, and § 686A.291, as set forth below.

232. Each enterprise was engaged in interstate commerce during the relevant times, and the activities of each enterprise affected interstate commerce during those times. Defendants provided medical services, and group health insurance for medical services, to persons who were residents of states other than Nevada. In furtherance of their business activities, Defendants contracted with and purchased from vendors located in states other than Nevada equipment and supplies that were delivered to Defendants' offices in Nevada from those other states by means of interstate transportation. In furtherance of their business activities, Defendants used the United States mails and interstate telephone and wire communications.

1. Humana as RICO "Enterprise" but not as RICO "Person"

233. Humana was an "enterprise" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c).

234. Each of Defendants Humana Insurance, Wendell Cherry, and/or William Larry Cash was a "person" within the meaning of Nev. Rev. Stat. 207.400(1), § 205.380, and § 686A.291.

2. Humana Insurance as Rico "Enterprise" but not as RICO "Person"

235. Humana Insurance was an "enterprise" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c).

236. Each of Defendants Humana, Wendell Cherry, and/or William Larry Cash was a "person" within the meaning of Nev. Rev. Stat. § 207.400(1), § 205.380, and § 686A.291.

3. The "Humana Group" as RICO "Enterprise"

237. Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance were members of an association-in-fact, hereinafter referred to as the "Humana Group," that constituted an "enterprise" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c).

238. Each of Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash, when not acting as a member of the enterprise, was a "person" within the meaning of Nev. Rev. Stat. § 207.400(1), § 205.380, and § 686A.291.

239. The Humana Group shared common purposes, exhibited distinct divisions of responsibility, existed independently of the pattern of racketeering activity, and continued as an economic unit with the same members at its core during the period from 1984 through 1988.

a. Membership of the Humana Group

240. The Humana Group included, along with Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash, the officers and directors of Humana and Humana Insurance, all companies that prepared and/or disseminated advertising for Humana and/or Humana Insurance, and all sales brokers who sold policies of group health insurance issued by Humana Insurance.

b. Purposes and Responsibilities of the Humana Group

241. The general purposes and responsibilities of the Humana Group were to provide medical services by Humana-Sunrise and insurance for medical services by Humana-Sunrise.

242. The specific purposes and responsibilities of Defendants Humana, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana, included without limitation providing medical services by Humana-Sunrise.

243. The specific purposes and responsibilities of Defendants Humana Insurance, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana Insurance, included without limitation providing insurance for medical services by Humana-Sunrise.

244. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana included without limitation promoting the sale of medical services by Humana-Sunrise.

245. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana Insurance and of sales brokers included without limitation promoting the sale of insurance for medical services by Humana-Sunrise.

c. Bases for the Humana Group

246. The bases for the association between and among Defendants Humana, Wendell Cherry, and William Larry Cash, and the officers and directors of Humana included without limitation the articles of incorporation and bylaws of the firm.

247. The bases for the association between and among Defendants Humana Insurance, Wendell Cherry, and William Larry Cash, and the officers and directors of Humana Insurance included without limitation the articles of incorporation and bylaws of the firm.

248. The bases for the association between Defendants Humana and Humana Insurance included without limitation the contractual preferred-provider agreements they entered into with each other.

249. The bases for the association between and among Defendant Humana and companies that prepared and/or disseminated advertising for Humana included without limitation contractual agreements that Humana entered into with each of them.

250. The bases for the association between and among Defendant Humana Insurance and companies that prepared and/or disseminated advertising for Humana Insurance included without limitation contractual agreements that Humana Insurance entered into with each of them.

251. The bases for the association between and among Defendant Humana Insurance and sales brokers included without limitation contractual agreements that Humana Insurance entered into with each of them.

d. Time Period of the Humana Group

252. The Humana Group was intended to continue for an indefinite period of time. It has in fact continued from 1984 to the date of filing of this Third Amended Complaint.

e. Culpability of the Humana Group

253. The only members of the Humana Group that were aware of all or a portion of the scheme to defraud and to obtain money by means of false pretenses were Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance.

D. Violations of Nev. Rev. Stat. § 207.400(1)(a)(2)

254. Each Defendant, other than when it was the enterprise, with criminal intent used or invested, directly or indirectly, to acquire an interest in or to establish or operate one of the alternative enterprises, proceeds the Defendant received that were derived, directly or indirectly, from racketeering activity, within the meaning of Nev. Rev. Stat. § 207.360(26), § 207.360(30), and § 207.400(1)(a)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

255. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A. 291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 270.400(1)(a)(2).

E. Violations of Nev. Rev. Stat. § 207.400(1)(c)(1)

256. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, the affairs of one of the alternative enterprises through racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26). § 207.360(30), and § 207.400(1)(c)(1), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

257. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(c)(1).

F. Violations of Nev. Rev. Stat. § 207.400(1)(c)(2)

258. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, through the affairs of that enterprise, racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26), § 207.360(30), and § 207.400(1)(c)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

259. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(c)(2).

G. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(a)(2)

260. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants to use or invest, directly or indirectly, for the purpose of acquiring an interest in or to establish or operate one of the alternative enterprises, proceeds derived, directly or indirectly, from racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26), § 207.360(30), and § 207.400(1)(a)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Rev. Rev. Stat. § 686A.291(3).

261. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(a)(2).

H. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(c)(1)

262. Each Defendant, other than when it was the enterprise, associated with one of the alternative enterprises and conspired, in violation of Nev. Rev. Stat. § 207.400(1)(h), with each of the other Defendants to conduct or participate in, directly or indirectly, the affairs of that enterprise through racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26). § 207.360(30), and § 207.400(1)(c)(1), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

263. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in

furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(c)(1).

I. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(c)(2)

264. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conspired, in violation of Nev. Rev. Stat. § 207.400 (1)(h), with each other Defendant to conduct or participate in, directly or indirectly, through the affairs of that enterprise, racketeering activity within the meaning of Nev. Rev. Stat. § 207,360(26), § 207.360(30), and § 207.400(1)(c)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

265. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A. 291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207. 400(1)(c)(2).

J. Requested Relief

266. By reason of the violations of Nev. Rev. Stat. § 195.020, and § 207.400 (1)(a)(2), (1)(c)(1), (1)(c)(2), and

(1)(h) committed by Defendants, it is estimated that the approximate actual damages of the RICO classes are in excess of $181,034,570.00, the principal of which is subject to trebling.

267. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

VIII

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $84,520,143.00 based on the ERISA violations by Humana Insurance, Wendell Cherry, and William Larry Cash on the First Claim for Relief.

2. Imposition of a constructive trust in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. Declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana Insurance and William Larry Cash to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. General, special, and compensatory damages in an amount in excess of $181,034,570.00 on the Second Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

5. For declaratory judgment and permanent injunction requiring Defendant to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Third Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

7. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Fourth Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

8. Costs of suit and fees incurred herein.

9. Any further and additional relief that this Court may deem just and equitable.

DATED this 31st day of October, 1991.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Las Vegas, Nevada 89101

WAITE, SCHNEIDER, BAYLESS
& CHESLEY CO., L.P.A.

By_____
STANLEY M. CHESLEY, ESQ.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, Ohio 45202

CUMMINGS, CUMMINGS & DUDENHEFER

By_____
JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

GAUTHIER & MURPHY

By_____
WENDELL GAUTHIER, ESQ.
3500 North Hullen Street
Metairie, LA 70002

ATTORNEY FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Suite 700
Las Vegas, Nevada 89101

Appendix A

Use of the United States Mails During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	2/7/89	H-Insurance	Andrews
2.	Premium invoice for 8/1/85 - 8/31/85	not shown	Humana, Inc.	Best Glass
3.	Premium invoice for 7/1/86 - 7/31/86	not shown	Humana, Inc.	Best Glass
4.	Premium invoice for 7/1/87 - 7/31/87	not shown	Humana, Inc.	Best Glass
5.	Premium invoice for 7/1/88 - 7/31/88	not shown	Humana, Inc.	Best Glass
6.	Letter soliciting policy renewal and quoting premiums	4/29/88	H-Insurance	Best Glass
7.	Cover letter for Humana Insurance brochure setting forth benefits of policy	not shown	H-Insurance	Bratton
8.	Humana Insurance enrollment form	9/10/87	Bratton	H-Insurance
9.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/22/88	H-Sunrise	Staves
10.	Patient account statement	3/21/88	H-Sunrise	Bratton
11.	Patient account statement	4/17/88	H-Sunrise	Bratton
12.	Patient account statement	5/20/88	H-Sunrise	Bratton
13.	Request for payment of charges by Humana-Sunrise	5/28/88	H-Sunrise	Bratton
14.	Patient account statement	6/11/88	H-Sunrise	Bratton

15.	Request for payment of charges by Humana-Sunrise	7/2/88	H-Sunrise	Bratton
16.	Patient account statement	11/12/88	H-Sunrise	Bratton
17.	Request for payment of charges by Humana-Sunrise	12/3/88	H-Sunrise	Bratton
18.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/31/89	H-Insurance	Bratton
19.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/8/89	H-Insurance	Bratton
20.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/23/89	H-Insurance	Bratton
21.	Patient account statement	6/26/89	H-Sunrise	Bratton
22.	Detailed statement of charges by Humana-Sunrise	9/22/86	H-Sunrise	Buehler
23.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Buehler
24.	Patient account statement	10/3/89	H-Sunrise	Buehler
25.	Detailed statement of charges by Humana-Sunrise	10/21/87	H-Sunrise	Cade
26.	Detailed statement of charges by Humana-Sunrise	9/18/86	H-Sunrise	Forsyth
27.	Patient account statement	10/25/86	H-Sunrise	Forsyth
28.	Statement of charges by Humana-Sunrise and amounts paid by insured	10/27/86	H-Sunrise	Forsyth
29.	Patient account statement	11/9/86	H-Sunrise	Forsyth

30.	Statement of charges by Humana-Sunrise and amounts paid by insured	12/24/86	H-Sunrise	Forsyth
31.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Staves
32.	Patient account statement	11/16/88	H-Sunrise	Staves
33.	Patient account statement	12/30/88	H-Sunrise	Staves
34.	Detailed statement of charges by Humana-Sunrise	1/9/89	H-Sunrise	Staves
35.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/9/89	H-Sunrise	Staves
36.	Patient account statement	1/9/89	H-Sunrise	Staves
37.	Patient account statement	1/10/89	H-Sunrise	Staves
38.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/11/89	H-Insurance	Staves
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40.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/19/89	H-Insurance	Staves
41.	Patient account statement	1/20/89	H-Sunrise	Staves
42.	Request for payment of charges by Humana-Sunrise	1/29/89	H-Sunrise	Staves
43.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	10/8/89	H-Insurance	Staves
44.	Patient account statement	10/10/89	H-Sunrise	Staves

Appendix B

Interstate Telephone and Wire Communications During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Approximately 14,000,000 interstate telephone communications involving business activities of Defendants [*see* Exhibit 1]	1984-1988	Defendants, Plaintiffs, and others	Defendants, Plaintiffs, and others
2.	Indeterminate number of interstate telephone Communications involving claims payments by Defendants [*see* Exhibit 2]	1987-1988	Defendants, Plaintiffs, and others	Defendants, Plaintiffs, and others
3.	Interstate telephone communications involving charges by Humana-Sunrise and co-payments by Humana Insurance [*see* Exhibit 3]	1986-1987	Rudolph K. Whalen [Arizona]	H-Sunrise [Nevada], H-Insurance [Nevada], Mutual Administrators [Nevada]
4.	Interstate telephone communication involving business activities of Defendants [*see* Exhibit 4]	5/2/89	John Andris of Humana, Inc. [Kentucky]	Herschell Dunham of Nevada Division of Insurance [Nevada]
5.	Interstate wire transfer of $1,501,335.63 [*see* Exhibit 5]	3/2/84	Humana, Inc. [Kentucky]	H-Insurance [Nevada]
6.	Interstate wire transfer of $ [illegible] [*see* Exhibit 6]	6/17/87	H-Insurance [Nevada]	First National Bank [Boston]

CERTIFICATION

I, William E. Lawrence, certify the following:

1. I am Vice President - Telecommunications for Humana Inc. and have been responsible for arranging local and long distance telephone services for Humana Inc. and its subsidiaries for eleven (11) years.

2. I have reviewed the Plaintiff's Fifth Request for Production of Documents in the case styled *Mary Forsyth, et al. vs. Humana Inc., et al.*, Case No. CV-S-89-249-PMP (LRL).

3. Long distance telephone records of Humana Inc. for the period 1984 through 1988, including those records of long distance calls made between the corporate office of Humana Inc. in Louisville, Kentucky and Humana Hospital-Sunrise and Humana Health Insurance of Nevada's market office, both located in Las Vegas, Nevada, are maintained in the form of copies of bills or invoices from various long distance carriers, and are in storage in Louisville, Kentucky.

4. In preparation to respond to Plaintiff's Fifth Request for Production of Documents, I reviewed several selected months' internal reports summarizing Humana's long distance telephone usage. Based upon my analysis of those records, I have estimated that for the period 1984 through 1988, approximately fourteen million (14,000,000) long distance telephone calls were made from Humana's corporate offices in Louisville, Kentucky to locations in Kentucky and other states, including calls made to Humana Hospital-Sunrise and Humana Health Insurance of Nevada's market office located in Las Vegas, Nevada. Also, among that estimated total are long distance telephone calls that originated at Humana Hospital-Sunrise and Humana Health Insurance of Nevada's market office in Las Vegas, Nevada, to other locations in Nevada and to locations in other states,

including calls to the corporate offices of Humana Inc. in Louisville, Kentucky.

I hereby certify that the foregoing is true and accurate to the best of my knowledge, information and belief.

/s/ William E. Lawrence
William E. Lawrence.

[Letterhead of Humana Health Care Plans, Las Vegas, Nevada]

November 13, 1987

Mr. Robert Evans
Supervisor Life and Health
Department of Commerce
Insurance Division
201 South Fall Street
Carson City, Nevada 89710

Re: Transfer of claims processing and payment from Mutual Administrators to Humana Corporate Claims System, Louisville, Kentucky.

Dear Bob,

The primary purpose for the above transfer is to better serve the consumer by providing them the claims, utilization and trend reports on a regular basis. By providing these reports, it will enable the consumer to better manage health care costs and provide a review of when employees and dependents are using health care services. These kinds of reports currently are not able to be generated on a regular basis through Mutual Administrators, Inc. Also, this will enable Humana Health Insurance of Nevada, Inc. to better comply with the recent proposed legislation in reporting data on health costs to the Department. The following is an outline of notification and implementation:

1. Notification:
   (a) Effective data of termination of contract is December 1, 1987.
   (b) Mutual Administrators, Inc. will be notified in person with letter on November 19, 1987.
   (c) All accounts will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

   (d) All brokers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.
   (e) All providers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.
   (f) Legal council has approved termination.

2. Responsibilities:
   (a) Mutual Administrators, Inc.
      (1) Through November 30, 1987, Mutual Administrators, Inc. will be responsible for all claims incurred and reported.*
      (2) Mutual Administrators, Inc. will be responsible for the runout.*
   (b) Humana Health Insurance of Nevada, Inc.
      (1) Currently Humana, in Las Vegas, has five customer service representatives, four trained and one to be trained by December 1, 1987.
      (2) Currently ten terminals with inquiry capabilities with wiring and equipment for an additional twelve stations, if necessary.
      (3) Additional personnel to be added as needed.
      (4) Twenty-four hour hot line service to Las Vegas office.
      (5) Seventeen lines available for consumer inquiries.
      (6) Additional 2400 square foot in current building for expansion.
      (7) An 800 number to Las Vegas office for customer service outside of Clark County.
      (8) Account will be set up at FIB in Nevada for claims payments.

---

* If Mutual Administrators, Inc. refuses to accommodate, Humana is prepared to assume the responsibility.

(c) Humana Corporate Claims - Louisville, Kentucky:
(1) Adjudicate and pay claims for Nevada.
(2) Produce cards - cards have been ordered (temporary cards for December 1, 1987 and new permanent cards by January 1, 1998.
(3) Plans loaded and tested successfully in Corporate system for implementation December 1, 1987 or earlier if necessary.
(4) An 800 number to Corporate customer service in addition to local customer service lines.
(5) Provide regular reports (see attached).
(6) Two Corporate claims managers will be in Las Vegas the week of November 9, 1987 for claims instruction and coordination.

b, if any other information is needed, please give me a call.

Sincerely,

/s/ John R. Egermayer
John R. Egermayer
Executive Director

JRE:dw

cc: Roger Collins
Larry Cash
Judy Zelinski
Joyce Anderson
Bruce McClure
Jerry McClellan
Joe Lawrence

AFFIDAVIT OF RUDOLPH KERRY WHALEN

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

RUDOLPH KERRY WHALEN, being first duly sworn, deposes and says:

1. I, Rudolph Kerry Whalen, am an adult and at all times relevant hereto was a resident of Riviera, Arizona.

2. This affidavit is offered on behalf of Plaintiffs in the matter of *Forsyth v. Humana, CV-S-89-249-PMP (LRL)*, in reference to Plaintiffs' Second Amended Complaint

3. In 1986 my wife was hospitalized at Humana Hospital-Sunrise in Las Vegas, Nevada. She was insured as my dependent pursuant to a policy of health insurance issued by Humana Insurance Co. of Nevada. Consequently I am a Plaintiff in this action.

4. In 1986 I placed telephone calls from my residence in Riviera, Arizona to the offices of Humana Hospital-Sunrise and Humana Insurance Co. of Nevada and/or its agent, Mutual Administrators, all of whom were located in Las Vegas, Nevada, concerning bills I had received from Humana Hospital-Sunrise for my wife's treatment there that Humana Insurance Co. of Nevada had delayed in paying, thereby causing Humana Hospital-Sunrise to demand that I pay those bills.

5. In 1987 my minor daughter was hospitalized at Humana Hospital-Sunrise in Las Vegas, Nevada. She was insured as my dependent pursuant to a policy of health insurance issued by Humana Insurance Co. of Nevada.

6. In 1987 I placed telephone calls from my residence in Riviera, Arizona to the offices of Humana Hospital-Sunrise and Humana Insurance Co. of Nevada and/or its agent,

Mutual Administrators, all of whom were located in Las Vegas, Nevada, concerning bills I had received from Humana Hospital-Sunrise for my daughter's treatment there that Humana Insurance Co. of Nevada had delayed in paying, thereby causing Humana Hospital-Sunrise to demand that I pay those bills.

7. At no time in the course of those telephone conversations in 1986 and 1987 did Humana Insurance Co. of Nevada and/or its agent, Mutual Administrators, ever inform me that Humana Insurance Co. of Nevada had entered into an agreement with Humana Hospital-Sunrise whereby Humana Hospital-Sunrise discounted the portion of those bills that Humana Insurance Co. of Nevada was obligated to pay, but not those portions of the bills that I was obligated to pay, and that Humana Insurance Co. of Nevada had not applied that discount to, or in any other manner reduced, the amount that I was obligated to pay.

DATED this 13th day of August, 1991.

/s/ Rudolph Kerry Whalen
RUDOLPH KERRY WHALEN

SUBSCRIBED and SWORN to before me this 13th day of August, 1991.

/s/ Janet L. Slone
NOTARY PUBLIC

[stamp—(SEAL)/Janet L. Slone/Notary Public-State of Nevada/
CLARK COUNTY/My Appointment Expires Jan. 14, 1994]

[Message Form—Tops Form 3002P]

IMPORTANT MESSAGE

FOR Herschell

DATE 5-2 TIME 11:20 A.M.

M John Andris

OF Humana (law Dept)

PHONE 502-580-3717

TELEPHONED ✓ PLEASE CALL ✓

MESSAGE Merger &
documents you
asked for regarding
exam

SIGNED SKK

[Letterhead of First Interstate Bank, Reno, Nevada]

March 9, 1984

Mr. David Reinhardt
Investment Management Department
Humana, Inc.
P. O. Box 1438
Louisville, Kentucky 40201

Dear Mr. Reinhardt:

Enclosed is the confirmation statement for the Treasury Bill purchased on March 2, 1984. Although the statement shows principal of $1,501,300.00, please let this letter confirm receipt from you for $1,501,355.63 by wire on March 2.

For your information, we have reserved a corporate demand account number 002-0011288 for Humana Health Insurance of Nevada, Inc. To complete required documentation, kindly fill in the items checked on the enclosed signature cards/ corporate resolution form and the taxpayer identification form, and return these at your earliest convenience.

We appreciate your selecting First Interstate Bank of Nevada, N.A. for your banking needs.

Sincerely,

/s/ Marvin M. Mann

MMM:aa

Enclosures

[Form AC-250T (0983), First Interstate Bank, Reno, NV]

Confirmation and Statement

Order No. 0011—T

We confirm according to the transaction code below and the terms stated hereon and the reverse side hereof. If this confirmation is not in all respects in accordance with your understanding, please notify us immediately.

Account Number (BLANK) Trade Date 3-1-84
Settlement Date 3-2-84 Security Number/Cusip (BLANK)

Humana Health Insurance
of Nevada, Inc.
C/O Marvin Mann

PRINCIPAL $1,501,350.00

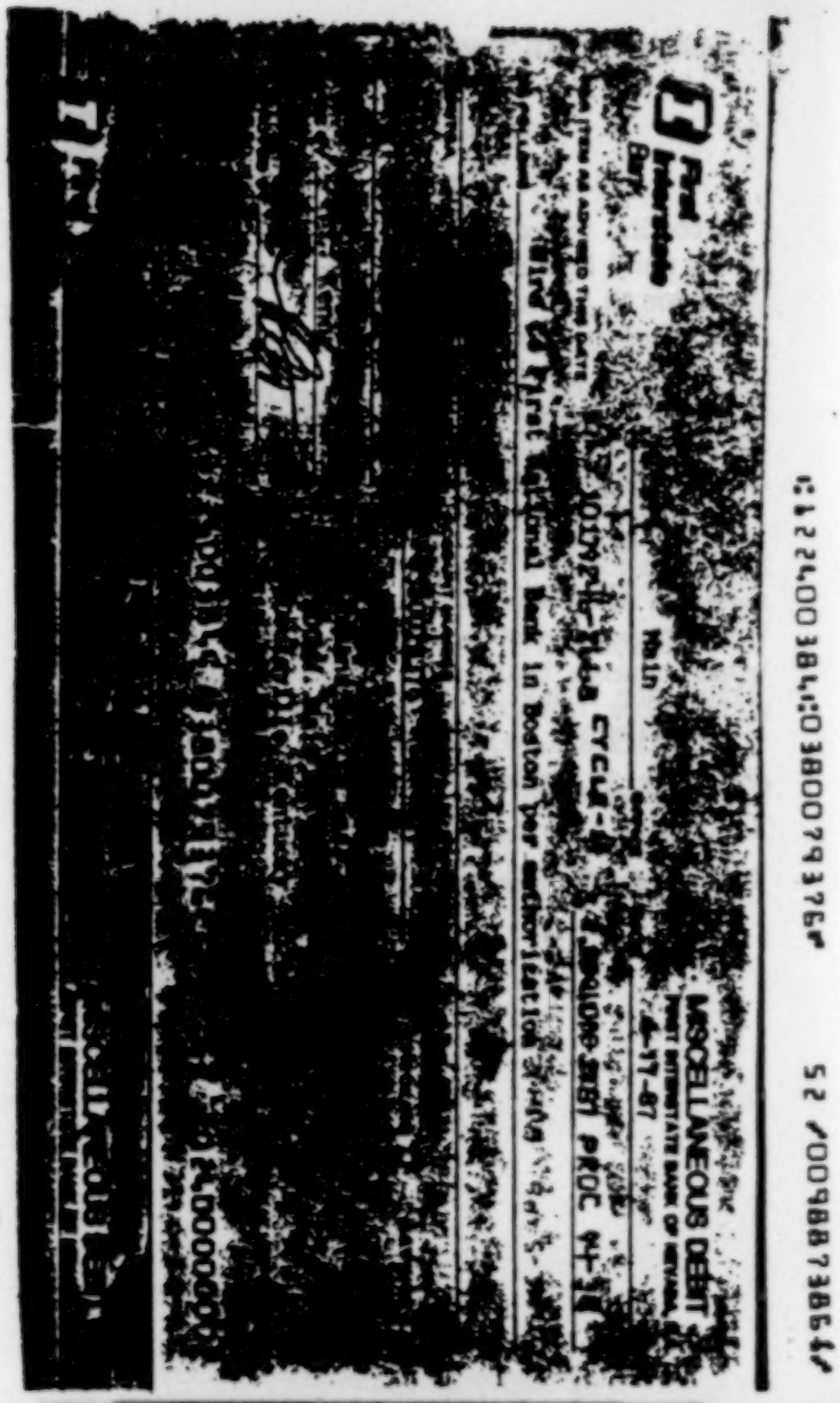
TOTAL AMOUNT DUE $1,501,350.00

Transaction X Sold Type I Tran Code 2
Trader/Salesman 2 Price 95,3238 Rate 9.30 Disc

Par Value $1,575,000.00 Yield 9.89

Description U.S. Treasury Bills Due 8-30-84

Payment and Delivery Instructions: Hold in Safekeeping



BEST AVAILABLE COPY

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
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700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH, et. al.

Plaintiffs,

vs.

HUMANA, INC., et, al.

Defendants.

PLAINTIFFS' MOTION FOR LEAVE TO FILE REVISED THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Motion for Leave to File Revised Third Amended Complaint and Jury Demand. This Motion is based on Fed. R. Civ. P. 15, the pleadings and papers on file with the Court, and the points and authorities set forth herein. Plaintiffs have drastically altered their former proposed Third Amended Complaint, deleting all new parties and any new claims other than Plaintiffs' 18 U.S.C. § 1503 allegations. These measures should eliminate the concerns expressed by the Court in its Order of December 6, 1991.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial Complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying Defendants' Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

On October 31, 1991, Plaintiffs filed their Motion for Leave to File a Third Amended Complaint (Exhibit 1). On November 15, 1991, Defendants filed their Opposition to that Motion (Exhibit 2). On November 25, 1991, Plaintiffs filed their Reply to that Opposition (Exhibit 3). On December 6, 1991, the Court issued an Order denying Plaintiffs' Motion (Exhibit 4).

II

ARGUMENT

A. Plaintiffs' Revised Third Amended Complaint Remedies the Stated Concerns of This Court.

In its Order denying Plaintiffs' first Motion for Leave, the Court stated:

> [T]he Court finds that Plaintiffs have failed to demonstrate that the proposed additions to the complaint could not have been included in earlier amendments. Plaintiffs have had numerous opportunities to apprise Defendants and this Court of all purported grounds for relief and any additional parties they to bring before the Court.

Order at 1. That previous Third Amended Complaint contained the following new claims and parties:

a. Federal RICO violations of 18 U.S.C. 1962(d) conspiracy to violate 18 U.S.C. 1962(a);

b. Federal RICO violations relating to 18 U.S.C. § 1503.

c. Violations of the Nevada RICO statutes;

d. Violations by additional Co-Defendants Wendell Cherry and William Larry Cash.

In the revised Third Amended Complaint attached hereto, Plaintiffs have responded to this Court's concerns by removing from the earlier version all of those new claims other than (b). Plaintiffs have additionally deleted all new parties.[1]

The revised Third Amended Complaint preserves Plaintiffs' claims regarding violations of 18 U.S.C. § 1503, on the grounds that those claims arose in their entirety after Plaintiffs' filed their Second Amended Complaint, and consequently Plaintiffs had no prior opportunity whatsoever to apprise Defendants or this Court of those claims. Plaintiffs believe they are entitled to pursue those claims in the interests of fairness and justice, and that for reasons of

---

[1] The present Motion does not constitute a waiver or abandonment by Plaintiffs of the claims, allegations, positions and arguments set forth in their first Motion for Leave or in their Reply to Defendants' Opposition thereto, or in the Third Amended Complaint that accompanied that Motion. Plaintiffs expressly reserve the right to pursue those matters at other times and in other forums.

judicial economy those claims ought to be joined in the present litigation.

In all other respects the revised Third Amended Complaint, now less than one-half the length of its predecessor, contains only the technical modifications and clarifications that appeared therein.

Fed. R. Civ. P. 15(a) allows a party to apply for leave to amend a pleading, and provides that "leave shall be freely given when justice so requires." One authority has observed that "[s]ubdivision (a) encourages the court to look favorably on requests to amend . . . . This proposition has been reinforced by innumerable judicial pronouncements by the federal appellate and district courts alike." 6 Charles A. Wright, Arthur R. Miller, & Mary K. Kane, *Federal Practice and Procedure* § 1483 (1990). Most significantly, the United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . the leave sought should, as the rules require, be "freely given."

Id., 371 U.S. at 182.

B. Plaintiffs' Revised Third Amended Complaint Does Not Prejudice Defendants.

In its Order this Court expressed concern that Plaintiffs had earlier opportunities to add new parties and allege new claims, yet they had not done so. The Court did not indicate, however, that Defendants were thereby prejudiced. And in fact Plaintiffs were not prejudiced by that proposed Third Amended Complaint.

Mere delay, absent significant prejudice to the opposing party, is not legally adequate grounds for denying a motion to amend. "It should be emphasized . . . that while laches and unexpected delay may bar a proposed amendment, *delay alone, regardless of its length, is not enough to bar it if the other party is not prejudiced.*" 3 James W. Moore, Richard D. Freer, *Moore's Federal Practice* ¶ 15.08[4], at 15-76 (2d ed. 1991) (emphasis added). If that were not true, then any motion to amend filed after some indeterminate period of delay might be denied for that reason alone, effectively imposing a deadline on motions to amend. Nothing in the Federal Rules of Civil Procedure indicates its drafters intended a restriction of that sort.

The Ninth Circuit has consistently reaffirmed this principle. The leading decision is *Howey v. United States*, 481 F.2d 1187 (9th Cir. 1973). In *Howey* the Plaintiff had delayed for five years in filing its motion to amend. As in the present instance, the trial court had not found prejudice; it denied the motion entirely by reason of the delay in amending. On appeal, the Ninth Circuit reversed, stating: "The crucial factor is the resulting prejudice to the opposing party." *Id.* at 1190. "We discern from the record that the district judge placed great weight on delay as a factor in his decision. . . . [T]he mere fact that the [plaintiff] could have moved at an earlier time to amend does not by itself constitute an adequate basis for denying leave to amend." *Id.* at 1191.

> *[W]e know of no case where delay alone was deemed sufficient grounds to deny a Rule 15(a) motion to amend.* Where there is a lack of prejudice to the opposing party and the amended complaint is obviously not frivolous, or made as a dilatory maneuver in bad faith, *it is an abuse of discretion to deny such a motion.* The purpose of the litigation process is to vindicate meritorious claims. Refusing, solely because of delay, to

> permit an amendment to a pleading in order to state a potentially valid claim would hinder this purpose while not promoting any other sound judicial policy. Only where prejudice is shown or the movant acts in bad faith are courts protecting the judicial system or other litigants when they deny leave to amend a pleading.

Id. at 1190-91 (citations omitted) (emphasis added).

The Ninth Circuit held firm to that principle in *United States v. Webb*, 655 F.2d 977 (9th Cir. 1981) and *Hurn v. Retirement Fund Trust of Plumbing, Heating and Piping Indus. of S. Cal.*, 648 F.2d 1252 (9th Cir. 1981). In *Webb* the court issued its ringing declaration that

> In exercising [its] discretion, a court must be guided by the underlying purpose of Rule 15—to facilitate decision on the merits, rather than on the pleadings or technicalities. Accordingly, Rule 15's policy of favoring amendments to pleadings should be applied with "*extreme liberality*."

Id. at 979 (emphasis added) (citations omitted). The court then reaffirmed the holding in *Howey*, citing as well Professor Moore's treatise: "The mere fact that an amendment is offered late in the case is . . . not enough to bar it." *Id.* at 980 (citation omitted).

In *Sierra Club v. Union Oil Co. of Cal.*, 813 F.2d 1480 (9th Cir.), *vacated on other grounds*, 485 U.S. 931 (1987), the court relied once more on *Howey*, noting additionally that "where a defendant is on notice of the *facts* contained in an amendment to a complaint, there is no serious prejudice to defendant in allowing the amendment." *Id.* at 1493 (emphasis added). In both their former and revised Third Amended Complaints, Plaintiffs have not alleged any new *facts* other than those set forth in their § 1503 claims. In the

former version, Plaintiffs merely alleged new legal theories; in the revised version, Plaintiffs have not even done that.

The court in *Sierra Club* additionally stressed the policy reasons for liberally granting motions to amend:

> General considerations of judicial economy also justify allowing the amendments. The violations included in the proposed amendment relate to the same subject matter as the original complaint. Allowing the amendment will further the federal policy of "wrapping in one bundle all matters concerning the same subject matter."

Id. at 1493 (citation omitted).

And as recently as March of 1991 the Ninth Circuit reiterated, in *United States v. Pend Oreille Public Utility Dist. No. 1*, 926 F.2d 1502 (9th Cir. 1991), that "the crucial factor is not length of delay, but prejudice." *Id.* at 1511 (citing *Howey*, inter alia).

For the foregoing reasons, Plaintiffs request that this Court allow them to file their revised Third Amended Complaint, without the addition of any new parties or claims other than those relating to 18 U.S.C. § 1503. Plaintiffs believe Defendants cannot even arguably assert any prejudice that might arise from granting that request, and consequently this Court ought to grant it in accordance with the clear mandate of the Ninth Circuit as set forth herein.

DATED this 13th day of December, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
300 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' MOTION FOR LEAVE TO FILE REVISED THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this 13th day of December, 1991.

LIONEL SAWYER & COLLINS

By /s/ Louis E. Garfinkel
LOUIS E. GARFINKEL, ESQ.
1600 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 13th day of December, 1991, the foregoing PLAINTIFFS' MOTION FOR LEAVE TO FILE REVISED THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

Mark J. Biros, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., #800
Washington, D.C. 20036

/s/ Jill S. Fletcher
An employee of JONES, JONES, CLOSE &
BROWN, CHARTERED

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH, et. al.

Plaintiffs,

vs.

HUMANA, INC., et, al.

Defendants.

ORDER

The Court having considered the arguments of counsel, and good cause appearing, it is hereby

ORDERED, that Plaintiffs may file their revised Third Amended Complaint.

DATED this ___ day of _____, 1991.

_____
UNITED STATES DISTRICT COURT JUDGE

Submitted By:

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
700 Valley Bank Plaza
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Metairie, LA 70002

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

THIRD AMENDED COMPLAINT AND JURY DEMAND

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Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, J. Randall Jones and Will Kemp of Jones, Jones, Close & Brown, Chartered; Stanley M. Chesley of Waite, Schneider, Bayless & Chesley Co., L.P.A.; John L. Cummings III of Cummings, Cummings & Dudenhefer; and Wendell Gauthier of Gauthier & Murphy, for their causes of action against Defendants complain, aver, and allege as follows:

I

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, et seq., the Employment Retirement Income Security Act ("ERISA"); these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc. under Sections 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. §§ 1961 - 1968. Subject matter jurisdiction is conferred on this Court by 15 U.S.C. §§ 15 & 16, 18 U.S.C. § 1964(c), 28 U.S.C. § 1331, 28 U.S.C. § 1337, 28 U.S.C. § 1367, and 29 U.S.C. § 1132

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 18 U.S.C. § 1965, 28 U.S.C. § 1391, and 29 U.S.C. § 1132.

3. Defendants Humana and Humana Insurance maintain offices and transact business and may be found within the District of Nevada. The interstate trade and commerce involved and affected by the alleged violations of the

antitrust laws is carried on, in part, within the District of Nevada. These claims arose within the District of Nevada. It is in the ends of justice that other parties be brought before this Court.

II

RELEVANT TIMES

4. The period of time relevant to this Third Amended Complaint is from 1984 to the present. Within that relevant period, (a) the breaches of fiduciary duties by Defendant Humana Insurance continued from 1984 through at least 1989; (b) Defendants' monopolization or attempts to monopolize have continued from 1984 to the present; (c) Defendants' scheme to defraud and to obtain money by false pretenses continued from 1984 through at least 1989, (d) Defendants' pattern of racketeering activities have continued from 1984 to the present; and (e) the duration of each of the three enterprises described *infra* has continued from 1984 to the present. This Court has limited the period of recovery herein to that for Defendants' acts and events occurring during the period from 1985 through 1988, inclusive.

III

PARTIES

5. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant Humana Health Insurance of Nevada, Inc. ("Humana Insurance") through payroll deductions.

6. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana

Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Mrs. Cade was at all times relevant Humana Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana Insurance policy. Robert Cade was hospitalized at Humana Hospital-Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

7. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and made premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through November 9, 1986. Pursuant to the 20% co-payment provisions, Ms. Andrews was obligated to pay and did pay a portion of all of her hospitalization costs.

8. Plaintiff Mary Lou Buehler, 210 Myers Avenue, Henderson, Nevada 89015, has been an insured with Humana Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in October of 1988, Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her charges for those hospitalizations were $23,293.94 and $2,736.85, respectively. Pursuant to the co-payment provision of her policy she was obligated to pay 20% of the costs of her hospitalization. Mrs. Buehler has paid a portion of the co-payment.

9. Plaintiff Helen Staves, HCR 65, Box 71408, Pahrump, Nevada 89041, has been insured with Humana Insurance since July 1988. At all times relevant, Ms. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital-Sunrise. Pursuant to the co-payment provisions under her policy, she was required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Ms. Staves paid her portion of the co-payment.

10. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987 Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital-Sunrise. At that time day surgery was performed on Mr. Bratton and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. ("Best Glass"), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has used Humana Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass's group number with Humana Insurance was 82801-18351-001. When Best Glass first became an insured with Humana Insurance, its premiums were very reasonable: $64.23 per employee per billing period. In 1986 those premiums increased by 3 percent, and in 1987 by 13 percent. Finally, in 1988, when Best Glass

decided not to renew with Humana Insurance, Humana Insurance sought a premium increase of 41 percent to continue coverage of employees of Best Glass.

12. Defendants did not inform individual Plaintiffs or Best Glass that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

13. Defendant Humana Health Insurance of Nevada, Inc. ("Humana Insurance") is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana Insurance is a wholly-owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. ("Group Health"). Humana Insurance markets and sells group health insurance through employee benefit plans to employers throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona, and Utah.

14. Defendant Humana, Inc. ("Humana") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has been for many years, one of the largest owners and operators of acute-care hospitals in the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana Hospital-Sunrise ("Humana-Sunrise") in Las Vegas, Nevada. Although Humana-Sunrise was only one of Humana's 87 hospitals in 1986, according to Humana's 1986 report to stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana

Resources in 1986, Humana-Sunrise generated 38 percent of Humana's pretax profits.

15. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOES I through X, inclusive, are not known to Plaintiffs at this time, who therefore sue those Defendants by fictitious names. Each of those Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will request leave to amend this Complaint to allege the true names and capacities of those Defendants when and as Plaintiffs ascertain them.

16. By order of this Court on September 26, 1989, Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade, Mary Lou Buehler, and Helen Staves (the "Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

17. By order of this Court on September 26, 1989, certain Plaintiffs (the "Antitrust Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

18. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves, and Best Glass (the "Antitrust Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

19. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Best Glass (the "RICO Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

20. By order of this Court on July 9, 1991, Plaintiffs Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, and Randolph Bratton (the "RICO Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

CLASS ACTION

IV

FIRST CLAIM FOR RELIEF

(Violations of ERISA)

21. The Co-Payor Class reasserts and realleges each and every allegation contained in paragraphs 1 through 22 of this Third Amended Complaint as though fully set forth at this point.

22. The Co-Payor Class consists of employees obtaining health insurance benefits under an employee benefit plan as defined under 29 U.S.C. 1001, et seq.

23. The members of the Co-Payor Class incurred charges at Humana-Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana Insurance was the insurer of the members of the Co-Payor Class through its group health insurance plan, Humana Care Plus.

A. Negotiation of the Secret Discount

24. On or about April 24, 1984, Humana and Humana Insurance negotiated a secret agreement that greatly reduced or discounted hospital charges for Humana Insurance patients incurring charges at Humana-Sunrise. Humana Insurance thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Humana Insurance was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

25. The aforementioned secret agreement between Humana and Humana Insurance specifically provided that Humana-Sunrise agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services.

B. Concealment of the Secret Discount

26. During the years 1985 and 1986 Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of those insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

C. Failure to Disclose the Secret Discount

27. During the years 1985 and 1986 Humana Insurance failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

D. Submission of the Fraudulent Master Policy

28. In 1984 Humana Insurance submitted for approval to the Insurance Division of Nevada a master policy of group health insurance. That master policy set forth terms, conditions, and representations that were to appear in all policies of group health insurance that Humana Insurance sought to market in Nevada, and was approved for that purpose by the Insurance Division of Nevada.

29. The aforementioned master policy, and the Humana Care Plus policies that conformed thereto, failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to those insureds the savings that Humana Insurance obtained by negotiating a discount on those charges.

30. The Humana Care Plus policies required that each member of the Co-Payor Class pay 20% of the charges for medical treatment at Humana-Sunrise. Humana Insurance agreed to pay the remaining 80% of those charges. The members of the Co-Payor Class believed, and their agreements with Humana Insurance provided, that the members of the Co-Payor Class and Humana Insurance would be paying their respective contractual percentages of the charges.

E. Sale of the Fraudulent Group Policies

31. During the period from 1984 through 1988 Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

F. Promotion of the Fraudulent Group Policies

32. Humana Insurance advertised its policies of group health insurance during the period from 1984 through 1988 and stated in those advertisements that Humana Insurance had reduced the costs of providing medical treatment and was passing along those savings to its insureds. In those advertisements Humana Insurance did not inform insureds that Humana Insurance was not passing along to them the savings it obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

33. Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

G. Failure to Pass Along Reduced Costs or Discounts

34. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the

period from 1984 through 1988 in they failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

H. Failure to Accomplish Exclusive Purpose of Providing Benefits and Defraying Costs of Administration

35. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana Insurance imprudently decided to retain the co-payment refunds that Humana Insurance negotiated with Humana. Humana Insurance received excessive compensation in violation of its fiduciary duties pursuant to 29 U.S.C. § 1104.

I. Failure to Adhere to Documents and Instruments Governing the Plan

36. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and 289, and 29 U.S.C. § 1104.

J. Failure to Discharge Duties With Diligence and Care

37. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use the conduct of an enterprise of a like character and with like aims.

K. Dealing in a Fiduciary's Self-Interest

38. Defendant Humana Insurance engaged in prohibited transactions in violation of its fiduciary duties during the period from 1984 through 1988 by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

L. Acting on Behalf of an Adverse Party

39. Defendant Humana Insurance engaged in prohibited transactions in violation of its fiduciary duties during the period from 1984 through 1988 by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

M. Receiving Consideration for a Fiduciary's Own Account

40. Defendant Humana Insurance engaged in prohibited transactions in violation of its fiduciary duties during the period from 1984 through 1988 by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

N. Requested Relief

41. It would be wrongful for Humana Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of the duties of Humana Insurance to the Co-Payor Class and of Humana Insurance's agreement with the Co-Payor Class.

42. A constructive trust should be imposed on Defendants that requires surrender of all monies obtained through the scheme described herein.

43. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

44. As a result of Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit on Defendant Humana Insurance. Defendant Humana Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of the scheme, Defendant Humana Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

45. The acts and practices of Defendants as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana Insurance.

46. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana Insurance, and it is estimated that the approximate actual damages are in excess of $84,520,143.00.

47. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

V

SECOND CLAIM FOR RELIEF

(Violations of Federal Antitrust Laws)

48. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 140 of this Third Amended Complaint as though fully set forth at this point.

49. The Antitrust Premium-Payer Class consists of individuals or entities paying all or a portion of the Humana Insurance premiums during the period from 1985 through 1988, including without limitation employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

50. Defendant Humana is in the business of owning and operating for-profit acute-care health facilities. Humana owns and operates a for-profit acute-care health care facility named Humana Hospital-Sunrise which provides hospital services in Las Vegas, Nevada.

51. Defendant Humana is also in the business of owning and operating group health care insurance companies, and in 1984 established one such company, Humana Insurance, with its principal place of business in Nevada.

52. The relevant geographic market for antitrust purposes is Clark County, Nevada or a portion thereof.

53. The relevant product market affected by Defendants' conduct is the sale of general, non-specialty, for-profit, acute-care hospital services or a portion thereof, and the group health insurance or health care financing market or a portion thereof.

54. Humana-Sunrise has possessed and exercised market power in the relevant geographic market during the class period. One indication of Humana-Sunrise's market power is its ability consistently to generate profit levels far above competitive levels found in comparable geographic markets, or as compared to national averages, or as compared to Humana hospitals located in other states. In addition to exercising this power within the market for the sale of general, non-specialty, for-profit, acute-care hospital services, the market power of Humana-Sunrise is heightened within relevant submarkets that may include only privately-owned hospitals, or other submarkets that focus on particular hospital products or services, especially as those products or services are obtained by private insureds.

55. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing and attempting to monopolize the above-described markets and/or submarkets.

56. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendants formed a symbiotic relationship between Humana-Sunrise and Humana Insurance, with Humana Insurance acting as a feeder mechanism to funnel Humana Insurance insureds into Humana-Sunrise, where those insureds became members of the Antitrust Co-Payor Class. Defendants established and maintained that relationship with the express purpose and effect of maintaining or enhancing the market power of Humana-Sunrise.

57. Humana and Humana Insurance engaged in a scheme that consisted of numerous actions, the primary purpose and effect of which was to maintain or enhance the market power of Humana-Sunrise.

58. As part of the aforementioned scheme, Humana-Sunrise Hospital and Humana Insurance entered into a secret

discount arrangement. Humana and Humana Insurance did not offer that discount arrangement to other insurance companies or to other general, non-specialty, for-profit, acute-care hospitals in the relevant geographic market, did not include Humana Insurance co-payers in that discount arrangement, and did not pass along to Humana Insurance co-payors the savings that Humana Insurance obtained from that discount arrangement. That discount arrangement additionally allowed Humana-Sunrise to conceal illegal profits.

59. As part of the aforementioned scheme, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred an unfair competitive advantage on Defendants.

60. As part of the aforementioned scheme, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

61. As part of the aforementioned scheme, Humana and Humana Insurance hospital engaged in additional actions, including without limitation the following:

A. Defendants promoted the use of services offered by Humana-Sunrise and discouraged the use of services offered by other general, non-specialty, for-profit, acute-care hospitals through Humana Insurance policies, by requiring extensive penalties for insureds who obtained services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise. Those penalties included without limitation the following:

1. Requiring a different and punitive deductible for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

2. Requiring a different and punitive co-payment for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

3. Applying a different standard of review when evaluating and paying claims from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise.

B. Humana engaged in a pattern of predatory pricing by offering Humana Insurance an unreasonable discount, while not offering that discount to other group health insurers in the relevant geographic market, nor to members of the Antitrust Co-Payor Class;

C. Humana Insurance required premiums for group health insurance policies that were anti-competitively high in comparison to premiums charged for comparable insurance by other group health care insurers in comparable geographic markets;

D. Humana Insurance initially engaged in predatory pricing within the relevant geographic market by attempting to undercut the premiums required for comparable insurance by other group health insurers in that market.

E. Humana Insurance required premiums for group health insurance policies that were far higher than those that normal actuarial practices would have indicated were reasonable for the percentages and amounts of co-payments of Humana-Sunrise's actual charges that members of the Antitrust Co-Payor Class paid.

62. The aforementioned scheme created misinformation among employers, insureds, and other third-party payers regarding hospital per diem arrangements and maximum potential discounts, thereby blunting competitive forces and allowing Humana-Sunrise to charge higher prices and offer less discounts than it could have without the scheme. In addition, because Humana Insurance misrepresented the risk-sharing provisions of its group health insurance plan, the premiums that Humana Insurance charged were artificially high, notwithstanding that at times those premiums may have been priced nominally lower than the premiums of comparable policies within the Clark County, Nevada area.

63. As a direct and proximate result of Defendants' market position and power, of their specific intent to maintain or enhance that market power, and of their actions to maintain or enhance that market power with a dangerous probability of success, the members of both the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class incurred antitrust injuries and damages. The members of the Antitrust Premium-Payor Class incurred antitrust injuries and damages in that they were required to pay premiums for Humana Insurance policies that were high in comparison to what competitive rates would have been in the absence of Humana's market power. The members of the Antitrust Co-Payor Class incurred antitrust injuries and damages in that

they were required to pay co-payments for Humana-Sunrise services that were high in comparison to what competitive rates would have been in the absence of Humana's market power.

64. Plaintiffs estimate that the approximate actual damages of the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class are in excess of $181,034,570.00, the principal of which is subject to trebling.

65. The anticompetitive acts and practices of Humana and Humana Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

VI

THIRD CLAIM FOR RELIEF

(Violations of Federal Racketeering Laws)

A. General Allegations

66. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 158 of this Third Amended Complaint as though fully set forth at this point.

67. Each Plaintiff and each member of the designated class that Plaintiffs represent is a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

68. With respect to their activities alleged herein, Defendants acted at all times with malice, intent, and knowledge, and with a wanton and reckless disregard for the rights of Plaintiffs.

69. With respect to the activities alleged herein, each Defendant aided and abetted each other Defendant, and others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and

specifically in violation of 18 U.S.C. § 2. Each Defendant agreed to the operation of the scheme to defraud and to obtain money by false pretenses.

70. With respect to the activities alleged herein, other than those involving violations of 18 U.S.C. 1962(d), each Defendant conspired with each other Defendant, and with others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of 18 U.S.C. § 1962(d). Each Defendant agreed to the conspiracy to defraud and to obtain money by false pretenses.

71. As part of a scheme to defraud Plaintiffs and to obtain money from Plaintiffs by false pretenses, by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana Insurance entered into a secret agreement (the "Agreement") whereby Humana-Sunrise agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and whereby Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services. Humana Insurance did not discount the portion of those charges paid by Plaintiffs but based them instead on the usual and customary rate.

72. Humana Insurance did not reduce premiums in the amount discounted. As a part of the scheme to defraud and to obtain money by false pretenses, Humana, and/or Humana Insurance used false and fraudulent pretenses, representations, and promises calculated to deceive persons of ordinary prudence and due care, and concealed and made material nondisclosures of facts and information important to the insureds, including without limitation the existence of the secret agreement and that Humana was billing Humana

Insurance at a different per diem, all so as to unlawfully, intentionally, and willfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed. R. Civ. P. 23.

73. The scheme to defraud and to obtain money by false pretenses evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which Humana and Humana Insurance carried out their broad objectives consisted of a complex pattern of individual transactions and group transactions.

74. As part of the scheme to defraud and to obtain money by false pretenses, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

75. As a part of the scheme to defraud and to obtain money by false pretenses, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, false, misleading, and fraudulent advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or

discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants.

B. Racketeering Activities

76. In carrying out the scheme to defraud and to obtain money by false pretenses, Defendants Humana and/or Humana Insurance engaged in, *inter alia*, conduct in violation of federal laws, viz., 18 U.S.C. § 1341, 18 U.S.C. § 1343, and 18 U.S.C. § 1503, as stated below:

1. 18 U.S.C. § 1341.

77. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false or fraudulent pretenses, representations, or promises, Defendants Humana and/or Humana Insurance placed in post offices, and/or in authorized repositories for mail matter, matters and things to be sent or delivered by the Postal Service, and received matters and things therefrom, and knowingly caused to be delivered by mail those matters and things according to the directions thereon or at the place at which they were directed to be delivered by the persons to whom they were addressed, including without limitation as set forth in Appendix 1.

(1) In those matters and things Defendants Humana and/or Humana Insurance falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Humana and/or Humana Insurance intentionally and

knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations.

(2) In those matters and things Defendants Humana and/or Humana Insurance falsely and fraudulently failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

Each such use of the mail during and in furtherance of the scheme to defraud and to obtain money by false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1341.

2. 18 U.S.C. § 1343.

78. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false pretenses, representations, and promises, Defendants Humana and/or Humana Insurance transmitted or caused to be transmitted in interstate commerce wire,

radio, and television transmissions, including without limitation as set forth in Appendix 2.

A. Defendants sent, or caused to be sent, interstate radio and television advertisements promoting the Humana Insurance group health insurance plan. Those radio and television advertisements were broadcast from locations in Nevada across state borders to persons located in Arizona and/or Utah. In those advertisements Defendants Humana and/or Humana Insurance never disclosed to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants. Defendants Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain in the form, inter alia, of a fraudulently unfair competitive advantage. The insureds reasonably relied on those nondisclosures.

B. Defendants used the interstate telephone lines to explain or discuss billings in order to collect co-payments from insureds for hospital charges incurred at Humana-Sunrise. Defendants maintained offices both in Las Vegas, Nevada and in Louisville, Kentucky. Defendants engaged in telephone conversations from their Nevada offices with Plaintiffs located in other

states, including without limitation Arizona, California, and Utah, and from their Kentucky offices with Plaintiffs located in other states, including without limitation Arizona, California, Nevada, and Utah. In those telephone conversations Defendants Humana and/or Humana Insurance falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana and/or Humana Insurance intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana and/or Humana Insurance failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

C. On or about December 1, 1987, Defendants established a Louisville Claims Center in Louisville, Kentucky and a toll-free telephone line to that office for the

specific purpose of handling claims from corporate Plaintiffs located in Nevada. Defendants engaged in telephone conversations from their Kentucky offices with corporate Plaintiffs located in Nevada. In those telephone conversations Defendants Humana and/or Humana Insurance falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana and/or Humana Insurance intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana and/or Humana Insurance failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

D. Defendants engaged in telephone conversations from their offices in Louisville, Kentucky with persons in Nevada in the offices of the government of the State

of Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses.

E. Defendants have certified that during the period from 1984 through 1988, they engaged in an estimated 14,000,000 interstate telephone conversations. Those telephone conversations were in support of the scheme to defraud and to obtain money by false pretenses.

F. Humana, Inc. and/or Humana Insurance transferred millions of dollars by wire transfer from Nevada to other states and from other states to Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses, including without limitation as set forth in Appendix 2. Those interstate transfers of funds were in support of the scheme to defraud and to obtain money by false pretenses.

Each such use of interstate wire transmissions during and in furtherance of the scheme to defraud and to obtain money by means of false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1343.

3. 18 U.S.C. § 1503.

79. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana and/or Humana Insurance corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, including without limitation:

A. Humana and Humana Insurance concealed from Plaintiffs 930 boxes or more of documents relevant to this litigation. Defendants' concealment of those 930 or more boxes of documents resulted in the improper suppression of evidence. Defendants concealed those

930 boxes or more of documents by multiple acts and omissions, including without limitation:

1. Defendants signed and served on Plaintiffs false responses to requests for production that Plaintiffs had issued to Defendants. In those responses Defendants failed to inform Plaintiffs of the aforementioned 930 boxes or more of documents that were responsive to Plaintiffs' requests, and Defendants failed to produce those 930 boxes or more of documents.

2. On or about August 30, 1991, Defendants falsely testified, in the sworn deposition of Defendants' counsel John Andris, that Defendants possessed none of the written documents contained in the aforementioned 930 boxes or more.

3. On or about September 4, 1991, Defendants falsely informed Plaintiffs that the only one to obtain the information that was in fact contained in the aforementioned 930 boxes or more of documents was by retrieving it from computer records at a cost of $200,000 to Plaintiffs.

Defendants in fact knew they were in possession of those 930 boxes or more of documents and that those documents were responsive to Plaintiffs' requests for production. Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice;

B. On or about January 18, 1990, Defendants signed, filed with this Court, and served on Plaintiffs a Second Motion to Dismiss, and on or about April 10, 1990, Defendants signed, filed with this Court, and served on

Plaintiffs a Reply to Plaintiffs' Opposition thereto, wherein Defendants falsely indicated they had not engaged in interstate wire communications. Defendants in fact knew they had engaged in more than 14,000,000 interstate telephone communications and numerous interstate wire transfers of funds. Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice.

C. On or about August 30, 1991, Defendants falsely testified, in the sworn deposition of Defendants' Director of Underwriting, James W. Keene, that Defendants had never maintained a "Jeopardy Committee." Keene in fact knew that Defendants had maintained a Jeopardy Committee over a period of several years, that he had routinely communicated with members of that committee, and that the committee had generated numerous documents and records. The significance of Defendants' Jeopardy Committee is that it was authorized to reduce premiums for group health insurance below the levels dictated by normal actuarial principles, and in flagrant disregard of the rating methodology that Humana Insurance represented to the Insurance Division of Nevada as determining the premiums that Humana Insurance charged. The intervention of the Jeopardy Committee thereby allowed Humana Insurance to sell or renew policies of group health insurance that Humana Insurance was otherwise in jeopardy of not selling or renewing. In addition, the intervention allowed Humana Insurance to set premiums so low that Humana Insurance operated at a loss, in violation of Nevada insurance regulations.

Each such act or omission to corruptly influence, obstruct, and impede, or endeavor to influence, obstruct, and impede,

the due administration of justice violated 18 U.S.C. § 2 and 18 U.S.C. § 1503.

80. At all times when Defendants Humana and/or Humana Insurance corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, this litigation was a pending judicial proceeding, and consequently this Court was engaged in the due administration of justice.

C. The RICO "Enterprise"

81. Plaintiffs allege three alternative "enterprises" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c), and, with respect to each of those alternatives, an alternative "person" or "persons" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c), as set forth below.

82. Each enterprise was engaged in interstate commerce during the relevant times, and the activities of each enterprise affected interstate commerce during those times. Defendants provided medical services, and group health insurance for medical services, to persons who were residents of states other than Nevada. In furtherance of their business activities, Defendants contracted with and purchased from vendors located in states other than Nevada equipment and supplies that were delivered to Defendants' offices in Nevada from those other states by means of interstate transportation. In furtherance of their business activities, Defendants used the United States mails and interstate telephone and wire communications.

1. Humana as RICO "Enterprise" but not as RICO "Person"

83. Humana was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

84. Defendant Humana Insurance, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

2. Humana Insurance as RICO "Enterprise" but not as RICO "Person"

85. Humana Insurance was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

86. Defendant Humana, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

3. The "Humana Group" as RICO "Enterprise"

87. Humana, Humana Insurance, and the officers and directors of Humana and Humana Insurance were members of an association-in-fact, hereinafter referred to as the "Humana Group," that constituted an "enterprise" within the meaning of 19 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

88. Each of Defendants Humana and Humana Insurance was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

89. The Humana Group shared common purposes, exhibited distinct divisions of responsibility, existed independently of the pattern of racketeering activity, and continued as an economic unit with the same members at its core during the period from 1984 through 1988.

a. Membership of the Humana Group

90. The Humana Group included, along with Defendants Humana, Humana Insurance, the officers and directors of Humana and Humana Insurance, all companies that prepared and/or disseminated advertising for Humana and/or Humana

Insurance, and all sales brokers who sold policies of group health insurance issued by Humana Insurance.

b. Purposes and Responsibilities of the Humana Group.

91. The general purposes of the Humana Group were to provide medical services by Humana-Sunrise and insurance for medical services by Humana-Sunrise.

92. The specific purposes and responsibilities of Defendant Humana and of the officers and directors of Humana included without limitation providing medical services by Humana-Sunrise.

93. The specific purposes and responsibilities of Defendant Humana Insurance and of the officers and directors of Humana Insurance included without limitation providing insurance for medical services by Humana-Sunrise.

94. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana included without limitation promoting the sale of medical services by Humana-Sunrise.

95. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana Insurance and of sales brokers included without limitation promoting the sale of insurance for medical services by Humana-Sunrise.

c. Bases for the Humana Group

96. The bases for the association between and among Defendant Humana and the officers and directors of Humana included without limitation the articles of incorporation and bylaws of the firm.

97. The bases for the association between and among Defendant Humana Insurance and the officers and directors

of Humana Insurance included without limitation the articles of incorporation and bylaws of the firm.

98. The bases for the association between Defendants Humana and Humana Insurance included without limitation the contractual preferred-provider agreements they entered into with each other.

99. The bases for the association between and among Defendant Humana and companies that prepared and/or disseminated advertising for Humana included without limitation contractual agreements that Humana entered into with each of them.

100. The bases for the association between and among Defendant Humana Insurance and companies that prepared and/or disseminated advertising for Humana Insurance included without limitation contractual agreements that Humana Insurance entered into with each of them.

101. The bases for the association between and among Defendant Humana Insurance and sales brokers included without limitation contractual agreements that Humana Insurance entered into with each of them.

d. Time Period of the Humana Group

102. The Humana Group was intended to continue for an indefinite period of time. It has in fact continued from 1984 to the date of filing of this Third Amended Complaint.

e. Culpability of the Humana Group

103. The only members of the Humana Group that were aware of all or a portion of the scheme to defraud and to obtain money by means of false pretenses were Humana, Humana Insurance, and the officers and directors of Humana and Humana Insurance.

D. Violations of 18 U.S.C.§ 1962(c)

104. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, the conduct of the affairs of that enterprise through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

105. Each Defendant, other than when it was the enterprise, aided and abetted each other Defendant, and persons not presently known to Plaintiffs, in committing the aforementioned violations of 18 U.S.C. 1962(c), all in violation of 18 U.S.C. § 2.

106. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

E. Violations of 18 U.S.C. 1962(d) conspiracy to violate 18 U.S.C. § 1962(a)

107. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(a) by using or investing, directly or indirectly, in the acquisition of any interest, income, or the establishment or operation of one of the alternative enterprises, part of income

derived, directly or indirectly, from a pattern of racketeering activity viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

108. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(a).

F. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(c)

1. Conduct or participation in the affairs of the enterprise

109. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly, in the conduct of the affairs of one of the alternative enterprises through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

110. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, ob-

struct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

2. Conduct or participation in a pattern of racketeering activity

111. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly, through the conduct of the affairs of one of the alternative enterprises, in a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

112. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

G. Requested Relief

113. By reason of the violations of 18 U.S.C. § 2 and § 1962(c) and (d) committed by Defendants, it is estimated that the actual damages of the RICO class are in excess of $181,034,570.00, the principal of which is subject to trebling.

114. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

VII

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $84,520,143.00 based on the ERISA violations by Humana Insurance on the First Claim for Relief.

2. Imposition of a constructive trust in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. Declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana Insurance and William Larry Cash to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. General, special, and compensatory damages in an amount in excess of $181,034,570.00 on the Second Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

5. Declaratory judgment and permanent injunction requiring Defendants to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Third Claim

for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

7. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Fourth Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00. Costs of suit and fees incurred herein.

8. Any further and additional relief that this Court may deem just and equitable.

DATED this 31st day of October, 1991.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
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WAITE, SCHNEIDER, BAYLESS
& CHESLEY CO., L.P.A.

By_____
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CUMMINGS, CUMMINGS & DUDENHEFER

By_____
JOHN L. CUMMINGS III, ESQ.
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GAUTHIER & MURPHY

By_____
WENDELL GAUTHIER, ESQ.
3500 North Hullen Street
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ATTORNEY FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
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300 South Fourth Street
Suite 700
Las Vegas, Nevada 89101

Appendix A

Use of the United States Mails During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	2/7/89	H-Insurance	Andrews
2.	Premium invoice for 8/1/85 - 8/31/85	not shown	Humana, Inc.	Best Glass
3.	Premium invoice for 7/1/86 - 7/31/86	not shown	Humana, Inc.	Best Glass
4.	Premium invoice for 7/1/87 - 7/31/87	not shown	Humana, Inc.	Best Glass
5.	Premium invoice for 7/1/88 - 7/31/88	not shown	Humana, Inc.	Best Glass
6.	Letter soliciting policy renewal and quoting premiums	4/29/88	H-Insurance	Best Glass
7.	Cover letter for Humana Insurance brochure setting forth benefits of policy	not shown	H-Insurance	Bratton
8.	Humana Insurance enrollment form	9/10/87	Bratton	H-Insurance
9.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/22/88	H-Sunrise	Staves
10.	Patient account statement	3/21/88	H-Sunrise	Bratton
11.	Patient account statement	4/17/88	H-Sunrise	Bratton
12.	Patient account statement	5/20/88	H-Sunrise	Bratton
13.	Request for payment of charges by Humana-Sunrise	5/28/88	H-Sunrise	Bratton
14.	Patient account statement	6/11/88	H-Sunrise	Bratton

15.	Request for payment of charges by Humana-Sunrise	7/2/88	H-Sunrise	Bratton
16.	Patient account statement	11/12/88	H-Sunrise	Bratton
17.	Request for payment of charges by Humana-Sunrise	12/3/88	H-Sunrise	Bratton
18.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/31/89	H-Insurance	Bratton
19.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/8/89	H-Insurance	Bratton
20.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/23/89	H-Insurance	Bratton
21.	Patient account statement	6/26/89	H-Sunrise	Bratton
22.	Detailed statement of charges by Humana-Sunrise	9/22/86	H-Sunrise	Buehler
23.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Buehler
24.	Patient account statement	10/3/89	H-Sunrise	Buehler
25.	Detailed statement of charges by Humana-Sunrise	10/21/87	H-Sunrise	Cade
26.	Detailed statement of charges by Humana-Sunrise	9/18/86	H-Sunrise	Forsyth
27.	Patient account statement	10/25/86	H-Sunrise	Forsyth
28.	Statement of charges by Humana-Sunrise and amounts paid by insured	10/27/86	H-Sunrise	Forsyth
29.	Patient account statement	11/9/86	H-Sunrise	Forsyth

30.	Statement of charges by Humana-Sunrise and amounts paid by insured	12/24/86	H-Sunrise	Forsyth
31.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Staves
32.	Patient account statement	11/16/88	H-Sunrise	Staves
33.	Patient account statement	12/30/88	H-Sunrise	Staves
34.	Detailed statement of charges by Humana-Sunrise	1/9/89	H-Sunrise	Staves
35.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/9/89	H-Sunrise	Staves
36.	Patient account statement	1/9/89	H-Sunrise	Staves
37.	Patient account statement	1/10/89	H-Sunrise	Staves
38.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/11/89	H-Insurance	Staves
39.	Patient account statement	1/12/89	H-Sunrise	Staves
40.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/19/89	H-Insurance	Staves
41.	Patient account statement	1/20/89	H-Sunrise	Staves
42.	Request for payment of charges by Humana-Sunrise	1/29/89	H-Sunrise	Staves
43.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	10/8/89	H-Insurance	Staves
44.	Patient account statement	10/10/89	H-Sunrise	Staves

Appendix B

Interstate Telephone and Wire Communications During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Approximately 14,000,000 interstate telephone communications involving business activities of Defendants [*see* Exhibit 1]	1984-1988	Defendants, Plaintiffs, and others	Defendants Plaintiffs, and others
2.	Indeterminate number of interstate telephone communications involving claims payments by Defendants [*see* Exhibit 2]	1987-1988	Defendants, Plaintiffs, and others	Defendants, Plaintiffs, and others
3.	Interstate telephone communications involving charges by Humana-Sunrise and co-payments by Humana Insurance [*see* Exhibit 3]	1986-1987	Rudolph K. Whalen [Arizona]	H-Sunrise [Nevada], H-Insurance [Nevada], Mutual Administrators [Nevada]
4.	Interstate telephone communication involving business activities of Defendants [*see* Exhibit 4]	5/2/89	John Andris of Humana, Inc. [Kentucky]	Herschell Dunham of Nevada Division of Insurance [Nevada]
5.	Interstate wire transfer of $1,501,335.63 [*see* Exhibit 5]	3/2/84	Humana, Inc. [Kentucky]	H-Insurance [Nevada]
6.	Interstate wire transfer of $ [illegible] [*see* Exhibit 6]	6/17/87	H-Insurance [Nevada]	First National Bank [Boston]

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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Motion for Leave to File Third Amended Complaint and Jury Demand. This Motion is based on Fed. R. Civ. P. 15, the pleadings and papers on file with the Court, and the points and authorities set forth herein.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial Complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying Defendants' Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

II

STATEMENT OF THE LAW

Fed. R. Civ. P. 15(a) allows a party to apply for leave to amend a pleading, and provides that "leave shall be freely given when justice so requires." One authority has observed that "[s]ubdivision (a) encourages the court to look favorably on requests to amend . . . . This proposition has been reinforced by innumerable judicial pronouncements by the federal appellate and district courts alike." 6 Charles A. Wright, Arthur R. Miller, & Mary K. Kane, *Federal Practice and Procedure* § 1483 (1990). Most significantly, the United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . the leave sought should, as the rules require, be "freely given."

Id., 371 U.S. at 182. *See also, e.g., United States v. Webb*, 655 F.2d 977 (9th Cir. 1981); *Hurn v. Retirement Fund Trust, Etc.*, 648 F.2d 1252 (9th Cir. 1981). In *Howey v. United States*, 481 F.2d 1187 (9th Cir. 1973), the Ninth Circuit reversed a denial of leave to amend, even five years after the initial complaint was filed, in the absence of prejudice to the defendant.

Plaintiffs' proposed Third Amended Complaint is additionally a supplemental pleading pursuant to Fed. R. Civ. P. 15(d). One of the reasons for the adoption of paragraph (d) is that otherwise a plaintiff might be forced into "commencing a new action even though events occurring after the commencement of the original action have made clear the right to relief." Fed. R. Civ. P. 15 advisory committee notes (1963). That is precisely the situation here.

III

ARGUMENT

1. Allegations regarding Defendants' RICO conspiracy.

Plaintiffs file this Third Amended Complaint to allege violations of 18 U.S.C. § 1962(d), i.e., a conspiracy to violate 18 U.S.C. §§ 1962(a) and (c) of the federal RICO statutes. In its Order of July 9, 1991, this court dismissed a portion of Plaintiffs' RICO claims pursuant to 18 U.S.C. § 1962(a). The Court adopted the rule of some federal circuits that Plaintiffs were required to establish an injury by reason of the use or investment of racketeering income. The Court concluded that Plaintiffs "have not alleged injury resulting from investment of racketeering income, and could not do so even if they had the chance to amend." Order at 38.

On August 16, 1990, after Plaintiffs had filed both their initial Complaint and their first Amended Complaint, the Ninth Circuit issued an opinion in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991) that addressed the requirements for establishing a *conspiracy* to violate 18 U.S.C. 1962(a), pursuant to the conspiracy portion of the RICO statutes, 18 U.S.C. § 1962(d). The Court held: "[A] plaintiff must have been injured by overt acts that are themselves statutorily defined acts of racketeering in order to have standing under § 1962(d)," *id.* at 295—i.e., by the predicate act itself, and not necessarily by the use or investment of racketeering income. In other words, the injury requirement for alleging a *conspiracy* to violate 18 U.S.C. § 1962(a), (b), or (c) leapfrogs those intermediate provisions and concentrates on the predicate act itself. Accordingly Plaintiffs now wish to amend their Complaint to allege that Defendants conspired to violate 18 U.S.C. § 1962(a) and (c).

2. Allegations regarding Wendell Cherry and William Larry Cash.

The proposed Third Amended Complaint additionally joins two culpable parties to this litigation: the estate of Wendell Cherry and its administrator, and William Larry Cash. Plaintiffs' grounds for joining those Defendants are set forth at length in the attached Third Amended Complaint 5-6 and *passim.*

3. Absence of prejudice to Defendants.

Granting Plaintiffs leave to file this Third Amended Complaint will not unduly prejudice Defendants, for the following reasons:

—Plaintiffs allege no new operative facts. The same transactions, occurrences, relationships, and injuries that animated Plaintiffs' earlier complaints remain at the core of this Third Amended Complaint. Hence this litigation will not assume any essential new character by reason of the allegations set forth in this proposed Third Amended Complaint.

—The additional co-Defendants were knowing, willful, and active participants in the scheme to defraud. Hence they were aware of the transactions, occurrences, relationships, and injuries alleged in this litigation even long before Plaintiffs filed their initial Complaint. Moreover, those additional co-Defendants were aware of this litigation itself from the outset thereof and of Plaintiffs' allegations therein.

—The parties to this litigation have engaged in relatively few essential depositions. By far the larger portion of those essential depositions remain to be scheduled. Plaintiffs alone presently contemplate scheduling more than twenty-five depositions hereafter.

—More than three months remain in this litigation for discovery efforts and motions. That is entirely adequate for Defendants to pursue all necessary discovery activities.

III

CONCLUSION

For all of the foregoing reasons, Plaintiffs respectfully request leave to file a Third Amended Complaint and Jury Demand in conformance with Exhibit 1.

DATED this 31st day of October, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ Will Kemp
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
300 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this ____ day of October, 1991.

LIONEL SAWYER & COLLINS

By_____
LOUIS E. GARFINKEL, ESQ.
1600 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 31st day of October, 1991, the foregoing PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

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/s/ Jill S. Fletcher
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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON ; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

ORDER

The Court having considered the arguments of counsel, and good cause appearing, it is hereby

ORDERED, that Plaintiffs may file their Third Amended Complaint.

DATED this ____ day of _____, 1991.

_____
UNITED STATES DISTRICT COURT JUDGE

Submitted By:

JONES, JONES, CLOSE
& BROWN, CHARTERED

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and Humana Health Insurance of Nevada, Inc.

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE No. CV-S-89-249-PMP (LRL)

MARY FORSYTH, *et al.*,

Plaintiffs,

v.

HUMANA, INC., *et al.*,

Defendants.

DEFENDANTS' MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT

I. INTRODUCTION

More than two and a half years after commencing this litigation, Plaintiffs have moved this Court for leave to file a

Third Amended Complaint. The Third Amended Complaint seeks to add new parties and new claims, and to revise the old claims against Defendants. Unfortunately, these amendments would alter the course and the pace of this action significantly.

Although the standards for leave to amend are liberal, leave should not be granted in every situation. Leave should be denied when it will prejudice the defendants or unduly delay the action without justification. Here, Defendants would be prejudiced because the Third Amended Complaint would effectively nullify Defendants' efforts over the past two and a half years to narrow and refine the scope of Plaintiffs' pleadings. In addition, the Third Amended Complaint would substantially delay this litigation by generating a renewed motion to dismiss and a renewed discovery process.

Furthermore, Plaintiffs cannot justify another amendment to their pleadings because the matters contained in the Third Amended Complaint generally could have been asserted in Plaintiffs' earlier pleadings and now will only cause further delay. It is time to move forward with this case to an adjudication on the merits. Defendants are eager for vindication in this litigation, but Plaintiffs' Third Amended Complaint will only delay the disposition of Plaintiffs' claims. Accordingly, Plaintiffs' motion for leave to amend should be denied.

II. STATEMENT OF FACTS

On March 29, 1989, Plaintiffs filed their original complaint with this Court, alleging claims under the Employee Retirement Income Security Act ("ERISA"), the Sherman Antitrust Act and various provisions of state law. On September 27, 1989, the Court dismissed Plaintiffs' state law claims and directed them to file an Amended Complaint re-asserting the ERISA and antitrust counts. Plaintiffs filed the Amended Complaint on October 27, 1989, alleging claims under ERISA and section 2 of the Sherman Antitrust

Act, and adding claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"). On July 9, 1991, the Court dismissed a portion of Plaintiffs' claims under RICO, and ordered Plaintiffs to file a Second Amended Complaint. The Second Amended Complaint was filed on August 12, 1991, which Defendants answered on September 4, 1991.

In the belief that Plaintiffs' allegations had finally been framed in the Second Amended Complaint, Defendants propounded extensive written discovery directed at exploring Plaintiffs' contentions in the Second Amended Complaint. On October 17, 1991, each Plaintiff's deposition was noticed in order to probe the bases of the allegations in the Second Amended Complaint. On September 11, 1991, all counsel met to confer on the discovery issues raised in the case. As a result of this meeting, the Court ordered the parties to complete all discovery by January 31, 1992. This order was based on the parties' September 18, 1991 status report to the Court which was prepared by both sides. At no point before or during the discovery conference did Plaintiffs indicate that they expected to amend their complaint a third time. Nonetheless, Plaintiffs now seek leave to file yet another amended complaint, containing two major changes.

First, the Third Amended Complaint attempts to join as defendants the Estate of Wendell Cherry ("Cherry"), the late president, chief operating officer, and director of Defendant Humana Inc.; and William Larry Cash ("Cash"), an officer and director of Defendant Humana Insurance. Plaintiffs' allegations do nothing more than attribute the activities of the existing Defendants to Cherry and Cash as individuals simply by virtue of their positions at Humana and Humana Insurance. Furthermore, Plaintiffs have not alleged that either of these parties committed acts unknown to the Plaintiffs on March 29, 1989, when they filed their original complaint.

Second, the Third Amended Complaint alleges additional acts by Defendants in connection with the ERISA claims, and changes their antitrust claims. Furthermore, Plaintiffs alter their allegations regarding the identity of the RICO "person" and "enterprise;" add new RICO conspiracy claims; and finally, introduce a new cause of action for violation of the Nevada racketeering laws. However, Plaintiffs introduce no facts to justify such amendments and changes.[1]

In sum, Plaintiffs' Third Amended Complaint attempts to raise legal theories that could have been asserted in earlier pleadings. Permitting Plaintiffs to now modify their claims will sacrifice judicial economy by triggering a new wave of motions and discovery, and will require Defendants to return their defense to square one. This could be costly to the Court and Defendants, and would extend the litigation. Because the Third Amended Complaint will materially prejudice Defendants and unduly prolong this action, Plaintiffs' motion for leave to amend should be denied.

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[1] Plaintiffs' amended RICO claim does include a new allegation that Defendants have committed an obstruction of justice under 18 U.S.C. § 1503. The allegation is based upon a series of purported discovery misconduct. These matters constitute discovery disputes. Thus, in connection with these same issues, Plaintiffs have filed a motion under Fed. R. Civ. P. 37 seeking discovery sanctions. Elevating these procedural skirmishes to a substantive criminal offense in this complaint seems hardly appropriate. Indeed, Plaintiffs' attempt to bootstrap discovery disputes into an additional cause of action is without precedent. Defendants have been unable to find any caselaw to support this effort. Plaintiffs, unfortunately, provide none either. Additionally, Plaintiffs' actions are anomalous. Plaintiffs specifically asked this Court to file their Rule 37 motion under seal, presumably to avoid impermissible interference with a pending jury trial ongoing in state court. Yet they make no such request with respect to the Third Amended Complaint, containing the same inflammatory allegations.

III. ARGUMENT

A. This Court Has The Discretionary Power To Deny Plaintiffs' Motion For Leave To File Their Third Amended Complaint.

Although Fed. R. Civ. P. 15(a) states that leave to amend a pleading "shall be freely given when justice so requires," the mere request for leave to amend does not create an entitlement to relief. Instead, the power to grant or deny leave is within the discretion of the district court. *Foman v. Davis*, 371 U.S. 178, 182 (1962). Under this standard, the district courts have developed several grounds for evaluating a request for leave to amend. First, "the district court's discretion to deny leave to amend is particularly broad where the court has already given the plaintiff an opportunity to amend his complaint." *See Fidelity Financial Corp. v. Federal Home Loan Bank of San Francisco*, 792 F.2d 1432, 1438 (9th Cir. 1986), *cert. denied*, 479 U.S. 1064 (1987).

Second, a court may properly deny leave to amend "if permitting an amendment would prejudice the opposing party, produce an undue delay in the litigation, or result in futility for lack of merit." *Jackson v. Bank of Hawaii*, 902 F.2d 1385, 1387 (9th Cir. 1990). *See generally Ascon Properties, Inc. v. Mobile Oil Co.*, 866 F.2d 1149 (9th Cir. 1989) (court denied leave for a third time because defendant would suffer prejudice); *McGlinchy v. Shell Chemical Co.*, 845 F.2d 802 (9th Cir. 1988) (leave denied, in part, because appellants should have been aware of their claim when they filed their original complaint, thereby causing undue delay); *Allen v. City of Beverly Hills*, 911 F.2d 367 (9th Cir. 1990) (allegations raised could not support a cause of action if added to the complaint).

Third, the trial court may deny leave when a party presents no new facts in the proposed pleading, but only seeks to introduce new theories without a satisfactory explanation for the failure to develop fully those contentions

originally. *Allen*, 911 F.2d at 374; *McGlinchy*, 845 F.2d at 809.

Using these three standards, this Court should reject Plaintiffs' attempt to file their *Third* Amended Complaint. Plaintiffs' primary justification for their Third Amended Complaint is the decision of the Ninth Circuit in *Reddy v. Litton Industries, Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3288 (1991). In this decision, according to Plaintiffs, the Ninth Circuit repudiated the "investment only" rule with respect to RICO conspiracy claims.

Even though Defendants believe Plaintiffs' interpretation of *Reddy* is erroneous,[2] there are other reasons why the *Reddy* decision does not justify Plaintiffs' request for leave to amend. First, *Reddy* was issued by the Ninth Circuit in August, 1990, more than one year ago and is not the very recent opinion Plaintiffs imply it is. Plaintiffs have had nearly sixteen months to advise the Court of the *Reddy* decision, to file an amended complaint with the Court, and to seek leave to amend their complaint to allege a RICO conspiracy in violation of § 1962(d). In fact, the *Reddy* decision was one year old when Plaintiffs filed their Second Amended Complaint on August 12, 1991, and they could easily have included a conspiracy claim under § 1962(d) in that complaint. Second, even if Plaintiffs can explain their failure to invoke *Reddy* earlier, it is a limited RICO ruling

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[2] The *Reddy* court specifically declined to abrogate the investment only rule. *Reddy*, 912 F.2d at 296. No case decided subsequent to *Reddy* supports Plaintiffs' interpretation. *See Saul v. United States*, 928 F.2d 829, 843 (9th Cir. 1991); *Price v. Hawaii*, 921 F.2d 950, 958 (9th Cir. 1990); *U.S. Concord, Inc. v. Harris Graphics Corp.*, 757 F. Supp. 1053, 1060-61 (N.D. Cal. 1991).

that does not justify Plaintiffs' attempt to introduce a wide variety of amendments in addition to a RICO conspiracy claim.[3]

Therefore, Plaintiffs' proposal to amend their complaint based upon *Reddy* should be viewed with skepticism. A detailed analysis of the individual amendments in the Third Amended Complaint demonstrates that this skepticism should result in a denial of Plaintiffs' request for leave to amend.

B. Plaintiffs Should Be Denied Leave To Join The Estate Of Wendell Cherry And William Larry Cash As Defendants.

On a purely equitable level, Plaintiffs never identify any reason, either in their motion or the proposed complaint itself, why either Cherry or Cash should, or must, be brought into this litigation at this late date. The corporate Defendants have not asserted that either Cherry or Cash acted outside the scope of their duties in an effort to preclude corporate liability for any action of the two individuals. Plaintiffs themselves have not alleged any action by the two individuals for which the corporate Defendants would not be liable.

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[3] In addition, the other cases cited by Plaintiffs in support of leave to amend are inapposite because they involved situations in which the only basis for objection to the amendment was a delay of the litigation. *See Foman v. Davis*, 371 U.S. 178, 182 (1962); *United States v. Webb*, 655 F.2d 977, 980 (9th Cir. 1981); *Hurn v. Retirement Fund Trust, Etc.*, 648 F.2d 1252, 1254 (9th Cir. 1981); *Howey v. United States*, 481 F.2d 1187, 1190-91 (9th Cir. 1973). Here, by contrast, Defendants have demonstrated that apart from undue delay, leave to amend is unjustified because Plaintiffs have failed to allege the development of new facts and Plaintiffs' amendment would prejudice Defendants significantly. *See Jackson*, 902 F.2d at 1387; *Ascon*, 866 F.2d at 1160-61.

Furthermore, the participation of Cherry and Cash as Defendants is not necessary to permit Plaintiffs to pursue their theories of liability. There is no legal necessity to name each of the alleged conspirators as defendants in order to recover from any other participant in the purported conspiracy.

One can only speculate as to why, two and a half years after this lawsuit was filed, Plaintiffs would now elect to label the recently-deceased president of one corporate Defendant and the vice president of the other as "racketeers."[4] This Court may exercise its discretion to avoid this unnecessary consequence of the requested amendment, with absolutely no prejudice to Plaintiffs' right to prosecute their claims.

Additionally, if the proposed amendments are evaluated on a purely legal basis, leave to amend as to Cherry and Cash should be denied for the reasons set forth below.

1. Prejudice to Defendants.

Leave to amend may be denied when it will prejudice the defendants. *See Jackson*, 902 F.2d at 1387; *McGlinchy*, 845 F.2d at 809; *Ascon*, 866 F.2d at 1160-61. In the instant case, Cherry and Cash will clearly be prejudiced if they are joined as parties. These individuals were never placed on notice of any potential individual liability when Plaintiffs

[4] Plaintiffs, in their Ninth Request for Production of Documents directed to Defendants, sought material from the Estate of Wendell Cherry. One can only hope that the decision to name Cherry's Estate is not an improper attempt to facilitate discovery or an unseemly prelude to a litigation strategy designed to exert emotional pressure upon the corporate Defendants through active litigation against the Estate. *See Webb*, 655 F.2d at 980 (bad faith amendment grounds for denying leave to amend). *See also Hurn*, 648 F.2d at 1254; *Howey*, 481 F.2d at 1190-91.

filed their earlier pleadings. It is manifestly unjust for these individuals now to be joined in litigation already two and a half years old; the action has taken a shape over which they had no control.

This is particularly true as to Cherry. Plaintiffs have known of the activities of Cherry at all times during this litigation, and waited until Cherry was deceased to name him as a party. This loss of access to a potentially vital witness is clearly prejudicial. *See Boris v. Moore*, 253 F.2d 523, 524 (7th Cir. 1958).

2. Delay of the Litigation.

Leave to amend also may be denied when it will result in a delay of the litigation. *See Ascon*, 866 F.2d at 1160-16 (leave denied because defendant would suffer prejudice due to substantial litigation costs already incurred and the prospect of additional time, expense and discovery); *Lewis v. Berry*, 109 F.R.D. 42, 43 (W.D. Wash. 1985) (additional claims would necessitate new discovery, additional motions and a postponement of trial which would be extremely prejudicial to parties).

Here, the addition of the individual Defendants will significantly prolong this action. For example, Cherry and Cash likely will move to dismiss the Third Amended Complaint.[5] Moreover, the addition of these individuals

[5] The liability of corporate officers for the activities of the corporation they serve is a real issue that must be examined by the Court. For example, the primary emphasis of Plaintiffs' new RICO theory is that the corporate Defendants, Cherry and Cash conspired to violate sections 1962(a) and 1962(c) of RICO, in violation of section 1962(d). But this attempt to impute liability is not supportable. No Ninth Circuit appellate cases have addressed the issue of whether a properly pled RICO conspiracy under § 1962(d) may consist solely of a corporation, its officers, em-

would expand the scope of the litigation and necessarily increase the time required to complete discovery without in any manner advancing Plaintiffs' theories of liability or facilitating proof of their claims.

3. Absence of New Facts.

A court may deny leave when the movant presents no new facts, only new theories based upon facts previously in

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ployees or subsidiaries. However, in a RICO case more recent than the *Reddy* case upon which Plaintiffs rely, and one which cites *Reddy*, the District Court in *U.S. Concord, Inc. v. Harris Graphics Corp.*, 757 F. Supp. 1053, 1060-61 (N.D. Cal. 1991), specifically ruled that a corporation may not be held liable under § 1962(d) for a conspiracy involving it, its employees and directors. This ruling follows the majority of District Court decisions which have decided the issue. *Compare Lawaetz v. Bank of Nova Scotia*, 653 F. Supp. 1278, 1287 (D.V.I. 1987); *H.G. Gallimore, Inc. v. Abdula*, 652 F. Supp. 437, 447 n.5 (N.D. Ill. 1987); *Gaudette v. Panos*, 650 F. Supp. 912, 913-14 (D. Mass. 1987), *rev'd on other grounds*, 852 F.2d 30 (1st Cir. 1988); *Satellite Financial Planning Corp. v. First Nat'l Bank of Wilmington*, 633 F. Supp. 386, 405 n.23 (D. Del. 1986); *Medallion TV Enterprises, Inc. v. SelecTV of California, Inc.*, 627 F. Supp. 1290, 1301 n.7 (C.D. Cal. 1986), *aff'd*, 833 F.2d 1360 (9th Cir. 1988), *cert. denied*, 109 S. Ct. 3241 (1989); *McLendon v. Continental Group, Inc.*, 602 F. Supp. 1492, 1510-12 (D. N.J. 1985); *with Pandick, Inc. v. Rooney*, 632 F. Supp. 1430, 1435-36 (N.D. Ill. 1986); *Callan v. State Chemical Mfg. Co., Inc.*, 584 F. Supp. 619, 623 (E.D. Pa. 1984); *Saine v. AIA, Inc.*, 582 F. Supp. 1299, 1307 (D. Colo. 1984). Only one circuit court has held that a conspiracy between a corporation and its employees may be proved, but under circumstances different from those alleged here. *See Ashland Oil, Inc. v. Arnett*, 875 F.2d 1271, 1281 (7th Cir. 1989). No other circuit courts have addressed the issue. Consequently, the attempt to include Cherry and Cash is legally defective. *See Foman*, 371 U.S. at 182 (futility of amendment is factor in denying leave to amend). *See also Webb*, 655 F.2d at 980; *Hurn*, 648 F.2d at 1254; *Howey*, 481 F.2d at 1190-91. More generally, there are a variety of other defenses which can be raised by Cherry and Cash which were not at issue until now.

existence, especially where, as here, there is no explanation why such theories were not developed earlier. *See Allen*, 911 F.2d at 374 (leave denied because movant presented no new facts, only a different legal theory); *Fidelity*, 792 F.2d at 1438 (leave denied because movant was reasserting prior claims under new labels with facts known to movant long before); *Sierra Club v. Union Oil Co. of Cal.*, 813 F.2d 1480, 1493 (9th Cir. 1987) ("where the party seeking the amendment knows or should know of the facts underlying the amendment when the original complaint is filed, the motion to amend may be denied"), *cert. granted, vacated*, 485 U.S. 931 (1988).

Plaintiffs do not allege any new facts in their Third Amended Complaint in their attempt to state a claim against Cherry and Cash. Instead, the Third Amended Complaint realleges the purported misconduct heretofore attributed to the corporate Defendants and merely alleges that the individual Defendants are liable in their official capacities. Such generic allegations against Humana's officers and directors could have been asserted in Plaintiffs' original complaint over two and a half years ago. Plaintiffs offer no explanation or justification as to why Cherry or Cash were not joined in any of their three earlier complaints or why these individuals should be joined at this late date.

Accordingly, the Court should deny Plaintiffs leave to join Cherry and Cash as defendants.

C. Plaintiffs Should Be Denied Leave To Add Additional Claims Against The Original Parties To This Litigation.

Plaintiffs also seek to amend their claims against the existing corporate Defendants. As noted above, this motion is based exclusively on the year-old decision of the Ninth Circuit in *Reddy* which, at best, is relevant only to an amendment of Plaintiffs' new RICO conspiracy claims.

However, without informing the Court in their motion, Plaintiffs have completely rewritten their claims under both ERISA and section 2 of the Sherman Act in their Third Amended Complaint; they have added a claim under Nevada's "little RICO" statute; and they have even revised the RICO claim under 18 U.S.C. § 1962(c), which the Court permitted Plaintiffs to pursue in its July 9, 1991 Order.

This tack is highly questionable because the significance of these proposed changes, especially to the ERISA and antitrust counts, is uncertain. Even after a detailed comparison of the allegations of the pending Second Amended Complaint and the claims set forth in the proposed Third Amended Complaint, it is not clear whether Plaintiffs intend to change the substance of their claims under ERISA and the antitrust laws. Before leave is granted, Plaintiffs should be required to answer these questions. Due to the existing ambiguities in Plaintiffs' proposed claims, however, the corporate Defendants are obliged to oppose the motion for leave to file the Third Amended Complaint.

1. Prejudice to Defendants.

The Court should deny Plaintiffs' leave to file the Third Amended Complaint because the amendment will substantially prejudice the corporate Defendants. *See Jackson*, 902 F.2d at 1387; *McGlinchy*, 845 F.2d at 809; *Ascon*, 866 F.2d at 1161 (leave to amend denied because filing of third complaint would prejudice defendants). A review of the facts demonstrates that prejudice would result if leave is granted.

First, defendants have endeavored over the past two and a half years to narrow and refine the scope of Plaintiffs' pleadings so that Defendants could prepare their defense to cognizable claims. Expending significant resources, Defendants have twice moved to dismiss Plaintiffs' claims for

pleading deficiencies which the Court recognized. However, after Plaintiffs filed their Second Amended Complaint, Defendants believed the issues to be adjudicated in this litigation had finally been framed and a course of discovery was charted. Now Plaintiffs request leave to file an amended pleading that will force Defendants to relitigate additional dispositive motions.

Second, Defendants have already propounded extensive written discovery tailored to ascertain the basis for particular allegations in the Second Amended Complaint. This discovery would be rendered moot by the Third Amended Complaint, forcing Defendants to issue new discovery requests. For these reasons, Defendants will be significantly prejudiced if this Court grants Plaintiffs leave to file the Third Amended Complaint.

Third, the timing of Plaintiffs' motion for leave to amend severely prejudices the corporate Defendants' ability to gather information relevant to Plaintiffs' claims. For the first time in two and a half years, Plaintiffs have suggested that Wendell Cherry was somehow uniquely involved in the alleged RICO conspiracies. Prior to Cherry's death, however, Plaintiffs not only refrained from making any such allegations, they did not even notice Cherry's deposition to determine if such allegations were proper. Plaintiffs' litigation strategy has effectively prevented Defendants from obtaining information regarding the alleged activities giving rise to liability from the best, if not, only source: Mr. Cherry himself.

2. Delay of the Litigation.

This Court also should deny Plaintiffs leave to amend because the filing of the Third Amended Complaint will unduly delay the litigation. *See Ascon*, 866 F.2d at 1161; *Lewis*, 109 F.R.D. at 43.

In a case of this magnitude, there is a need to gain control of the facts and issues within a reasonable time. Thus, the Court has established a discovery cut-off date. The parties have already embarked on a pattern of discovery in an effort to meet the Court's discovery deadline. An amendment to Plaintiffs' complaint at this time would require another motion to dismiss and additional discovery that probably could not be completed within the current discovery period.

Moreover, Plaintiffs' addition of a state RICO claim and federal RICO conspiracy claims to this class action requires a new class certification procedure pursuant to Fed. R. Civ. P. 23(c)(1). *See Zenith Laboratories, Inc. v. Carter-Wallace, Inc.*, 64 F.R.D. 159, 164 (D.N.J. 1974), *aff'd*, 530 F.2d 508 (3d Cir.), *cert. denied*, 429 U.S. 828 (1976). If these new claims were certified for class action treatment, class members would require a new notice of their right to opt out of the litigation. *See* Fed. R. Civ. P. 23(c)(2); *Matarazzo v. Friendly Ice Cream Corp.*, 70 F.R.D. 536, 560 (E.D.N.Y. 1976). The delay caused by this procedure warrants the denial of leave to amend. *See Matarazzo*, 70 F.R.D. at 560 (leave to amend denied because of delay caused by need to deliver new opt-out notice).

In sum, the addition of the claims set forth in the Third Amended Complaint would delay this litigation significantly.

3. Absence of New Facts.

This Court has the discretion to deny leave to amend when the movant attempts to change its theories of liability without alleging the occurrence of any new facts to support such theories. *See Allen*, 911 F.2d at 374.

Plaintiffs seek to expand their ERISA claims by adding alleged instances of misconduct by Defendants. For example, Plaintiffs contend that Defendants submitted a fraudulent master policy to the Insurance Division of Nevada. *See* Third Amended Complaint at ¶¶ 50-51. This is a new theory of recovery based upon facts that could have been asserted in any of Plaintiffs' earlier pleadings. The submission of the master policy to the Insurance Division was known to Plaintiffs when they initiated this suit in March, 1989, and Plaintiffs offer no explanation as to why the introduction of this fact has been delayed until the present time.

These same problems may exist as to the antitrust claim, even though Plaintiffs have developed no new facts to support this effort. Plaintiffs have had three previous opportunities to fine tune their antitrust claim, and without the assertion of recently discovered facts, they should not be permitted to do so again.

With respect to their RICO claim, Plaintiffs propose to modify their definitions of the RICO "persons" and the RICO "enterprise," and to add RICO conspiracy claims. Plaintiffs have also, at this late stage, moved the Court for leave to add a Fourth Claim for Relief alleging violations of Nevada racketeering laws. This state law claim could have been asserted in Plaintiffs' original complaint. These amendments amount only to shifts in Plaintiffs' legal theories. Plaintiffs have offered no explanation as to why these claims for relief were not raised in their earlier complaints.

IV. CONCLUSION

For the foregoing reasons, Defendants respectfully request that this Court deny Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand.

Respectfully submitted,

By: /s/ Mark Biros/FPH
Mark J.Biros
Thomas H. Brock
CASSON & HARKINS
1233 20th Street, N.W., Suite 800
Washington, D.C. 20036-2396
(202) 778-1100

Dated: November 15, 1991

By: /s/ [illegible]
for Dennis L. Kennedy
Louis E. Garfinkel
LIONEL SAWYER & COLLINS
300 So. Fourth St., Suite 1700
Las Vegas, Nevada 89101
(702) 383-8888

Attorneys for Defendants
Humana Inc. and Humana
Health Insurance of Nevada, Inc.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of Defendants' Memorandum of Points and Authorities in Opposition to Plaintiffs' Motion for Leave to File Third Amended Complaint was deposited in the U.S. mail at Las Vegas, Nevada, enclosed in a sealed envelope upon which first-class postage was fully prepaid, addressed to:

Stanley M. Chesley, Esq.
Wait, Schneider, Bayless
& Chesley Co., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, Ohio 45202

John J. Cummings, III, Esq.
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416 Gravier Street
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Gautheir and Murphy
3500 N. Hullen street
Metairie, Louisiana 70002

W. B. Markovits, Esq.
Markovits & Greiwe
119 E. Court Street, Suite 500
Cincinnati, Ohio 45202

on this ___ day of _____, 1991.

_____
An employee of
Lionel Sawyer & Collins

RECEIPT OF COPY

Receipt of copy of Defendants' Memorandum of Points and Authorities in Opposition to Plaintiffs' Motion for Leave to File Third Amended Complaint is hereby acknowledged this 15 day of Nov, 1991.

JONES, JONES, CLOSE & BROWN

/s/ J. Randall Jones
J. Randall Jones, Esq.
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101-6026

[Letterhead of Casson, Harkins & Greenberg, Washington, D.C.]

September 27, 1991

VIA TELECOPY

J. Randall Jones, Esq.
Jones, Jones, Close & Brown
700 Valley Bank Building
300 South Fourth Street
Las Vegas, Nevada 89101-6026

Re: *Forsyth v. Humana*

Dear Randall:

As promised, enclosed please find a list of persons who should be able to testify concerning the matters raised in the eighty (80) depositions you noticed previously. For convenience, I have noted across from the name of the person categories to which they can respond. Enclosed is a list of the deposition categories referenced below.

Ken Grubb	3, 23
Don Stewart	4, 5, 12, 15, 16, 17, 24, 25, 34
John Egermayer	4
Gary Mann	5, 15, 16, 17, 35, 36, 37
David Wills	6
Jerry McClellan	9, 11, 29, 31
Bruce Scott	1, 2, 4, 5, 8, 12, 13, 33
Jerry Miller	15, 16, 35, 36
Gary Metcalf	25, 35, 36, 37
Glenn Bossmeyer	26
Joan Kroger	10, 30
Darlene Curlee	10, 30

Lori Wojtowicz	31
George Atkins	34
John Grady	18, 38
Dee Jordan	18, 38
Rich Robinson	3, 23
Alice Newton	10, 30
Helen Faith	1, 2, 4, 5, 8, 12
Carol Stitt	4, 5, 12, 14, 15, 16, 17
Sharon Hicks	6
Larry Carlton	5, 15, 16, 17
Sam Hazen	4, 5, 12, 14, 15, 16, 17
Carol Pullin	19, 20
D. Jones	28
Maureen Cash	19, 20
James Bohanon	24, 25, 35, 36, 37
W. Larry Cash	1, 2, 4, 5, 8, 12, 21, 22, 24, 25, 26, 28, 32

Please call me to work out the schedule.

Very truly yours,

/s/ Mark J. Biros
Mark J. Biros

cc: John Andris
Dennis Kennedy
Louis Garfinkel

[wpj:00480ltr7]

CUSTODIAN OF RECORDS DEPOSITION CATEGORIES

1. HHIN's failure to reduce co-payments or share discounts given by Humana Inc. for per diem hospital charges
2. HHIN retention of co-payment refunds negotiated with Humana Inc.
3. Names of premium payors and what premiums were paid [HIN's premiums]
4. Discussions by HHS, HHIN, GHI to increase or maintain number of patients utilizing HHS
5. Decision $125 per diem or other discount comparable to one between HI and HHIN would/would not be provided/offered to other group health insurers for patients treated at HHS
6. AB 289 required HHI to pass along difference between #125 per diem and rate charged others
7. Monopolizing major for-profit acute-care facilities in Clark County, NV by HI, HHIN, GHI
8. Decision to charge different co-payment for obtaining services from any non-Humana for-profit acute-care hospitals than for doing so from HHS
9. Policies or standard of review for evaluating and paying claims from patients who were treated at non-Humana for-profit acute-care hospitals, as opposed to HS
10. All records of HI, GHI, HHIN re directors meeting from 1/84 til present re HHS $125 per diem discount or NV operations of Defendants
11. Policies for claims review of patients of HHS who were insured by HHIN during 1984-1988

12. Monies rebated between HI and HHIN from 1984 til present based on $125 per diem for in-patient hospitalization and any other rebate 40% or greater of actual billed charges
13. Transactions posted to general ledger accounts in support of "policy claims liability account" and contributed surplus account for 1983-1988
14. Meetings in 1989 between State of Nevada Governor and Humana employees
15. Records re HHS hospital charges for services for 1984-1988 to charges for same or similar services at for-profit acute-care facilities
16. 1983-1988 records re comparative studies of HHS with other hospitals as to rates charged, percentage returned on investment, net operating income
17. HHS's profit margins whether gross or not, from 1985 to present as compared with other acute-care facilities
18. Any correspondence during 1984-1988 with persons insured by HICN that explained any benefits or limitations of their insurance policies
19. Records that refer or relate to Mutual Administrators
20. Records received from Mutual Administrators per termination of contract between Mutual Administrators and HICN

PERSON MOST KNOWLEDGEABLE DEPOSITION CATEGORIES

21. HHIN's failure to reduce co-payments or share discounts given by Humana Inc. for per diem hospital charges
22. HHIN retention of co-payment refunds negotiated with Humana Inc.
23. Names of premium payors and what premiums were paid [HIN's premiums]
24. Discussions by HHS, HHIN, GHI to increase or maintain number of patients utilizing HHS
25. Decision $125 per diem or other discount comparable to one between HI and HHIN would/would not be provided/offered to other group health insurers for patients treated at HHS
26. AB 289 required HHI to pass along difference between $125 per diem and rate charged others
27. Monopolizing major for-profit acute-care facilities in Clark County, NV by HI, HHIN, GHI
28. Decision to charge different co-payment for obtaining services from any non-Humana for-profit acute-care hospitals than for doing so from HHS
29. Policies or standard of review for evaluating and paying claims from patients who were treated at non-Humana for-profit acute-care hospitals, as opposed to HS
30. All records of HI, GHI, HHIN re directors meeting from 1/84 til present re HHS $125 per diem discount or NV operations of Defendants
31. Policies for claims review of patients of HHS who were insured by HHIN during 1984-1988

32. Monies rebated between HI and HHIN from 1984 til present based on $125 per diem for in-patient hospitalization and any other rebate 40% or greater of actual billed charges

33. Transactions posted to general ledger accounts in support of "policy claims liability account" and contributed surplus account for 1983-1988

34. Meetings in 1989 between State of Nevada Governor and Humana employees

35. Records re HHS hospital charges for services for 1984-1988 to charges for same or similar services at for-profit acute-care facilities

36. 1983-1988 records re comparative studies of HHS with other hospitals as to rates charged, percentage returned on investment, net operating income

37. HHS's profit margins whether gross or not, from 1985 to present as compared with other acute-care facilities

38. Any correspondence during 1984-1988 with persons insured by HICN that explained any benefits or limitations of their insurance policies

[seb:00480chart]

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ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

PLAINTIFFS' REPLY TO DEFENDANTS' OPPOSITION TO MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Reply to Defendants' Opposition to Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand. This Reply is based on pleadings and papers on file with the Court and the points and authorities set forth herein.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial Complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying that Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

On October 31, 1991, Plaintiffs filed their Motion to File Third Amended Complaint and Jury Demand ("Motion") (Exhibit 1). On November 15, 1991, Defendants filed their Opposition ("Opposition") (Exhibit 2).

II

INTRODUCTION

Five compelling reasons argue for granting the proposed Third Amended Complaint:

1. The overwhelming weight of authority has long since established that leave to amend is granted with extreme liberality. In opposing Plaintiffs' Motion, Defendants have cited merely a few scattered decisions where courts denied leave to amend only after dismissing the plaintiffs' claims or issuing summary judgment against them.

2. Defendants offered no grounds for assuming prejudice to themselves. Any delay that Plaintiffs' proposed Amendment might occasion is simply inconsequential by comparison with the enormous delays that Defendants themselves have brought to this matter.

3. Defendants are not even in a position to argue, on behalf of Cherry and Cash, that Plaintiffs' proposed Third Amended Complaint might prejudice those individuals—especially when Cherry and Cash themselves have raised no objections. Beyond that, the objections Defendants raise are altogether meritless. Cherry and Cash are not only appropriate individuals for Plaintiffs to name; they are the *most* appropriate individuals, according to information provided by Defendants themselves—and only *after* Plaintiffs filed their Second Amended Complaint. Moreover, the proposed amendment does not in fact prejudice Cherry and Cash. To the contrary, its timing may well benefit them, allowing Cherry and Cash to save thousands of dollars by

drawing on the litigation and discovery efforts that Defendants have already completed.

4. Defendants have offered no grounds for this Court to ignore the Ninth Circuit decision in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991), a decision issued well *after* Plaintiffs filed their first Amended Complaint and one that the United States Supreme Court refused to overturn only *after* Plaintiffs filed their Second Amended Complaint.

5. Nor have Defendants even attempted to offer any grounds for this Court to deny Plaintiffs an opportunity to recover for Defendants' violations of 18 U.S.C. § 1503—once more, violations that occurred or that Plaintiffs discovered only *after* filing their Second Amended Complaint.

Accordingly the path is clear for this Court to grant Plaintiffs' Motion; and, in the interests of both justice and judicial economy, it may do so without reservation.

III

ARGUMENT

1. Leave to Amend is Granted with *Extreme Liberality*

The most compelling observation on granting leave to amend a complaint that has issued from the Ninth Circuit appeared in *United States v. Webb*, 655 F.2d 977 (9th Cir. 1981):

> In exercising this discretion, a court must be guided by the underlying purpose of Rule 15—to facilitate decision on the merits, rather than on the pleadings or technicalities. Accordingly, Rule 15's policy of favoring amendments to pleadings should be applied with "*extreme liberality*."

Id. at 979 (emphasis added) (citations omitted).

Defendants have cited a few isolated instances where courts denied leave to amend, plucking from each of those decisions a few abstract principles as if they were ripe plums. Yet Defendants have otherwise disregarded the meat of those decisions, the specific situations that prompted the courts to deny leave to amend. Most significantly, *every one of the decisions* cited and relied on by Defendants *followed a dismissal of the complaint or a summary judgment against the plaintiff*. Defendants have not cited *even one decision* where a court denied leave to amend after refusing to dismiss the action—or, for that matter, after *twice* refusing to dismiss the action, as in the present instance.

In the very first decision cited by Defendants, *Foman v. Davis*, 371 U.S. 178 (1962), the Court in fact *granted* leave to amend. That is the reason Plaintiffs themselves cited *Foman* in their Motion, at 2.

Defendants have then cited *Fidelity Financial Corp. v. Federal Home Loan Bank of San Francisco*, 792 F.2d 1432 (9th Cir. 1986), *cert. denied*, 479 U.S. 1064 (1987), for the proposition that "the district court's discretion to deny leave to amend is particularly broad where the court has already given the plaintiff an opportunity to amend his complaint," Opposition at 6, *citing Fidelity*, 792 F.2d at 1438. Yet in *Fidelity* the Ninth Circuit refused to grant leave to amend when the court below had already issued summary judgment for the Defendant, and because the plaintiff "was simply restating its prior claims under new labels." *Fidelity*, 792 F.2d at 1438. The present litigation contrasts sharply with that situation. Here the Court has not granted summary judgment for Defendants; to the contrary, it has recently *denied* almost all of defendants' protracted efforts to dismiss Plaintiffs' claims. Here Plaintiffs' Motion is not even arguably an effort to resurrect meritless claims in a new guise.

The same situation that obtained in *Fidelity* arose in *Jackson v. Bank of Hawaii*, 902 F.2d 1385 (9th Cir. 1990), only more so. In *Jackson* the court below had already dismissed all save one of the plaintiffs' claims. The court then heard a motion for summary judgment on that remaining claim and a motion for leave to amend. As in *Fidelity*, the court granted summary judgment and denied the motion to amend.

Moreover, in *Jackson* the plaintiffs had alleged RICO violations only of 18 U.S.C. § 1962(a) and (b). On appeal, the Ninth Circuit ruled that "these additional claims advance different legal theories and require proof of different facts." In the present matter, by contrast, Plaintiffs have sought merely to add *conspiracy* involving the 18 U.S.C. § 1962(a) and (c) violations that Plaintiffs have long since alleged. Any additional facts necessary to establish that conspiracy are altogether minimal.

Similarly, Plaintiffs' allegations implicating the Nevada RICO statutes are essentially coextensive with Plaintiffs' federal RICO allegations. The clearest evidence of this lies in the proposed Third Amended Complaint itself, wherein the first 11 paragraphs of the Nevada RICO allegations, apart from the specific statutes cited, are absolutely identical to the first 11 paragraphs of the federal RICO allegations. The same is true of the 23 paragraphs numbered 231 - 253 in the Nevada RICO portion; those are absolutely identical to the 23 paragraphs numbered 174 - 196 in the federal RICO portion.

Defendants then cite *Ascon Properties, Inc. v. Mobil Oil Co.*, 866 F.2d 802 (9th Cir. 1989), noting that the court denied leave to file a third amended complaint. What Defendants neglect to report is that the court in that matter had earlier dismissed *both* the first amended complaint *and* the second amended complaint. Clearly the court had lost patience with the plaintiff's efforts to fashion a valid claim for relief.

Similarly, in *McGlinchy v. Shell Chemical Co.*, 845 F.2d 802 (9th Cir. 1988), the court had granted summary judgment against the plaintiffs, and in *Allen v. City of Beverly Hills*, 911 F.2d 367 (9th Cir. 1990), the court had dismissed the complaint. The situation in *Allen* was especially dissimilar to that in the present litigation. In *Allen* the court refused to grant leave on grounds of futility, i.e., that the plaintiff could not possibly identify any grounds for recovery. Here, by contrast, Plaintiffs' initial pleadings have already handily survived two hard-fought battles over dismissal, and this Court has even *reinstated* one of Plaintiffs' claims that it had earlier disallowed. *See* Order of July 9, 1991, at 23-25.

Defendants have strained and failed to locate even one decision where a court denied leave to amend in a situation comparable to the one here. Plaintiffs' proposed Third Amended Complaint is a perfectly reasonable measure, designed to reduce some of the technical deficiencies arguably present in its predecessors, and to set forth in one final, comprehensive form all of the claims that Plaintiffs believe should be joined before this Court in the present litigation. For reasons of judicial economy and in the interests of justice, this Court ought to grant Plaintiffs' Motion.

2. The Proposed Third Amended Complaint is a Natural Evolutionary Development in This Litigation

A broader perspective on the course of this litigation may be in order. On October 27, 1989, after this Court had denied Defendants' first Motion to Dismiss, Plaintiffs filed their first Amended Complaint. On November 17, 1989, Plaintiffs stipulated to allow Defendants an additional 15 days to file their Answer by December 12, 1989. On December 13, 1989, Plaintiffs stipulated to allow Defend-

ants an additional five weeks to file their Answer by January 18, 1990. Finally, on January 18, 1990, more than two and a half months after Plaintiffs had filed their first Amended Compliant, Defendants filed, instead of an Answer, a Second Motion to Dismiss.

For almost eighteen months thereafter, Plaintiffs and Defendants disputed the issues in that Second Motion to Dismiss. By the time this Court denied that Motion, nearly two and a half years had passed in this litigation and *Defendants had not yet even filed an Answer*.

This Court held a hearing on that Second Motion to Dismiss on September 25, 1990, scarcely one month after the decision in *Reddy*, and *Reddy* had not yet come to the attention of Plaintiffs at the time of that hearing. Defendants now contend that Plaintiffs were obligated to amend their allegations after that hearing, while this Court was weighing the Second Motion to Dismiss, rather than awaiting the Court's ruling on that Motion. After the interminable delays caused by Defendants' two Motions to Dismiss, however, Plaintiffs wanted to resolve those issues and finally obtain an Answer.

By the time this Court denied that Motion and granted Plaintiffs leave to file a Second Amended Complaint, Plaintiffs were considering a variety of amendments that have now surfaced in their proposed Third Amended Complaint. Plaintiffs regarded the Second Amended Complaint as merely an interim effort, filed principally to cure a defect in the First Amended Complaint and to compel an Answer from Defendants.

Plaintiffs then enlisted the assistance of nine attorneys and numerous experts from across the United States to draft a comprehensive Third Amended Complaint that might withstand any prospective scrutiny, in this Court or on any level of appeal. That process required rather more than the one

month available to Plaintiffs for filing their Second Amended Complaint. Plaintiffs nonetheless managed to complete the proposed Third Amended Complaint in slightly more than three months.

Defendants contend that they "would be prejudiced because the Third Amended Complaint would effectively nullify Defendants' efforts over the past two and a half years to narrow and refine the scope of Plaintiffs' pleadings," Opposition at 2; *see also id.* at 14. Yet in many respects the proposed Third Amended Complaint is a direct outgrowth of Defendants' efforts "to narrow and refine" the issues in this litigation, to correct areas that might otherwise remain problematic. That is true, for instance, of Plaintiffs' revisions concerning the RICO "person" and the RICO "enterprise." It is ironic that Defendants now oppose those and other modifications and clarifications that were prompted in large measure by Defendants' own efforts.

Defendants additionally contend that they "have already propounded extensive written discovery tailored to ascertain the basis for particular allegations in the Second Amended Complaint. This discovery would be rendered moot by the Third Amended Complaint," Opposition at 14-15. Defendants' attempts to portray the proposed Third Amended Complaint as a complete departure from its predecessors are grossly misplaced. Countless paragraphs in the Second Amended Complaint have survived intact in this newer version, including many that formed the bases for Defendants' written discovery. For that reason Plaintiffs have already expended hundreds of hours in researching and preparing their responses to Defendants' discovery requests, once more enlisting the assistance of at least six attorneys and several experts — all at a cost to Plaintiffs of many thousands of dollars — and Plaintiffs have every intention of delivering those responses to Defendants by or before their present due date of December 2, 1991. If Plaintiffs believed

those responses might be "rendered moot" by the proposed Third Amended Complaint, then Plaintiffs would have long since filed a motion to stay the deadline for filing those responses, pending this Court's ruling on Plaintiffs' Motion for Leave to Amend.

The specter that Defendants have raised of "requir[ing] Defendants to return their defense to square one," Opposition at 5, is not only a chimera; it represents a monumental hypocrisy. By far the greatest discovery burden during the course of this litigation has fallen and continues to fall on Plaintiffs, not on Defendants. It is Plaintiffs, not Defendants, who have every reason to want this matter concluded promptly. It is Plaintiffs, not Defendants, who have repeatedly sought to move this matter along to a final resolution. Conversely, it is Defendants, not Plaintiffs, who have pursued an ongoing strategy of endless delay and dilatory tactics, and whose discovery abuses have even prompted this Court to impose monetary sanctions. When the parties filed a Joint Discovery Conference Report this past September 18, it was Plaintiffs who requested an end to discovery within six months, while it was Defendants who requested an additional year. The Court then set a discovery deadline of January 31, 1992, and Plaintiffs have no intention of attempting to pursue discovery beyond that date. Any efforts at additional delay in this litigation will emanate from Defendants, not from Plaintiffs. Moreover, given that Defendants had initially sought an additional twelve months for discovery, their ardent defense of the four-month deadline this Court imposed reveals itself as nothing more than opportunistic posturing.

Defendants' position in this regard, moreover, is markedly ambivalent. At the same time that Defendants contemplate "return[ing] their defense to square one," they concede that "Plaintiffs do not allege any new facts in their Third Amended Complaint in their attempt to state a claim against

Cherry and Cash." Opposition at 12. Yet almost the entirety of the ERISA and RICO claims in the proposed Third Amended Complaint set forth parallel and identical allegations against Humana, Humana Insurance, Wendell Cherry, and William Larry Cash. If Plaintiffs have not alleged any new facts regarding Cherry and Cash, then Plaintiffs have not alleged any new facts regarding Humana and Humana Insurance. And if Plaintiffs have not alleged any new facts regarding Humana and Humana Insurance, then Defendants are scarcely compelled to "return their defense to square one."

In truth, the *substance* of Plaintiffs' proposed Third Amended Complaint differs from that of its predecessor only in its new allegations involving 18 U.S.C. § 1503.[1] In essentially all other respects the proposed Third Amended Complaint merely incorporates technical improvements. It vitiates no prior discovery, nor requires any new discovery, other than with respect to those § 1503 allegations.

3. Plaintiffs' Claims Against Wendell Cherry and William Larry Cash Are Proper

a. Humana and Humana Insurance Have No Standing to Argue Prejudice Against Cherry and Cash

When Plaintiffs filed their Motion to File the proposed Third Amended Complaint, they served a copy of that Motion and the proposed Complaint on both the administra-

---

[1] Defendants lament that "even after a detailed comparison of the allegations of the pending Second Amended Complaint and the claims set forth in the proposed Third Amended Complaint, it is not clear whether Plaintiffs intend to change the substance of their claims under ERISA and the antitrust laws. Before leave is granted, Plaintiffs should be required to answer these questions." Opposition at 13-14. Plaintiffs believe the proposed amendments speak for themselves and require no collateral analysis, interpretation, or amplification by Plaintiffs. In the interest of moving these matters along, however, Plaintiffs respond to Defendants' questions as follows: No.

tor of the estate of Wendell Cherry and on William Larry Cash *personally* on November 4, 1991. Hence both of those prospective co-Defendants have had an opportunity to respond to that Motion by filing opposing amici briefs with this Court. They have not done so. This Court has not heard one word from Cherry and Cash in opposition to the proposed Complaint. The only opposition to that Complaint has come from the present Defendants, Humana and Human Insurance. And insofar as Defendants' objections involve alleged prejudice only to Cherry and Cash, Defendants simply have no standing to raise those objections.

Moreover, Defendants contend only that "Cherry and Cash will clearly be prejudiced if they are joined as parties," Opposition at 10, without ever alleging that Defendants themselves — the present Defendants, consisting of Human and Humana Insurance — will be prejudiced in any manner. Every argument in Defendants' Opposition concerning prejudice to the present Defendants involves amendments *other* than the addition of Cherry and Cash as co-Defendants.

b. Cherry and Cash Are Appropriate Candidates for Plaintiffs' Proposed Amendment

As executive officers and directors of Humana and Humana Insurance, Cherry and Cash had a close and even intimate relationship with the present Defendants. One authority has observed that "plaintiffs have been allowed . . . to add or substitute parties where there is an extremely close corporate or other relationship between the original and added defendant, and accrues no prejudice to the new party," 3 James W. Moore, Richard D. Freer, *Moore's Federal Practice* ¶ 15.05[5] (2d ed. 1991). Courts have so allowed in the first circuit (*see, e.g., Ayala Serrano v. Collazo Torres*, 650 F. Supp. 722 (D.P.R. 1986); the second circuit (*see, e.g., Holiday Publishing Co. v. Gregg*,

330 F. Supp. 1326 (S.D.N.Y. 1971); the third circuit (*see, e.g., Gram v. May*, 41 F.R.D. 52 (E.D. Pa. 1966); the fifth circuit (*see, e.g., Wedgwood v. Fiberboard Corp.*, 706 F.2d 541 (5th Cir. 1983); the seventh circuit (*see, e.g., Clark v. Universal Builders, Inc.*, 501 F.2d 324 (7th Cir.), *cert. denied*, 419 U.S. 1070 (1974); and the tenth circuit (*see, e.g., United States for use of Construction Specialties Co. v. Travelers Ins. Co.*, 40 F.R.D. 316 (D. Colo. 1966). The only contrary decisions cited in *Moore* occurred in Pennsylvania, and the most recent of those was in 1962. In *Ayala Serrano*, the court expressly ruled that "where the proposed party's interests are sufficiently aligned with those of the original defendant, the latter is presumed to give notice of suit to the former." *Ayala Serrano*, 650 F.Supp. at 726 (citations omitted).

c. New Facts Have Arisen Concerning the Involvement of Cherry and Cash

As noted *supra*, one of Defendants' objections is that

> Plaintiffs do not allege any new facts in their Third Amended Complaint in their attempt to state a claim against Cherry and Cash. Instead, the Third Amended Complaint realleges the purported misconduct heretofore attributed to the corporate Defendants and merely alleges that the individual Defendants are liable in their official capacities. Such generic allegations against Humana's officers and directors could have been asserted in Plaintiffs' original complaint over two and a half years ago. Plaintiffs offer no explanation or justification as to why Cherry or Cash were not joined in any of their three earlier complaints or why these individuals should be joined at this late date.

Opposition at 12-13. Plaintiffs believe no "explanation or justification" is legally required to name new parties who caused harm to Plaintiffs. Plaintiffs additionally observe that

the decisions Defendants cite for the proposition that "new facts" are necessary, *see id.* at 12, do not involve the addition of new *parties*, only of new *claims*.

Beyond that, however, Defendants' argument is ill-founded. Although Plaintiffs have not alleged "new facts" regarding the *violations* that Defendants committed, Plaintiffs have, in reality, alleged "new facts" regarding the specific *involvements* of Cherry and Cash in committing those violations. Many of those new facts, moreover, have come to light only as Defendants grudgingly responded to Plaintiffs' discovery requests, and some of them only quite recently.

Perhaps the most graphic demonstration of those new facts arose on September 27, 1991, after Plaintiffs had filed their Second Amended Complaint. Plaintiffs had sought to depose the custodians of records and persons most knowledgeable at Humana and Humana Insurance with respect to numerous issues. Defendants then informed Plaintiffs that in some instances the same individual might qualify as the custodian or person most knowledgeable for more than one issue, and accordingly Defendants prepared a list identifying those individuals. That list appears as Exhibit 3.

In that list, the individual that counsel for Defendants identified as the custodian and person most knowledgeble regarding far more issues than anyone else was William Larry Cash. *Counsel for Defendants identified Cash as the custodian and person most knowledgeable regarding the following*

> —Why Humana Insurance failed to reduce the copayments required of its insureds or otherwise to pass along or share with its insureds the discount, rebate, or refund it was given by Humana for per diem hospital charges;

> —Why Humana Insurance retained copayment refunds that it negotiated with Humana;
>
> —Efforts by Humana-Sunrise, Humana Insurance, or Group Health Insurance, Inc. to maintain or increase the number of patients using Humana-Sunrise;
>
> —Any decision that the $125 per diem or other discount comparable to the one between Humana and Humana Insurance would or would not be provided or offered to any other group health insurers for patients who were treated at Humana-Sunrise;
>
> —Any consideration, discussion, or research by Defendants as to whether AB 289 required Humana Insurance to pass along to or share with insureds, in the form of premium refunds, rebates, or reductions, the difference between the $125 per diem and the rate charged others;
>
> —The decision to charge a co-payment for obtaining services from any non-Humana for-profit acute-care hospitals different from the co-payment for obtaining services from Humana-Sunrise;
>
> —Monies rebated between Humana and Humana Insurance, including without limitation rebates, refunds, or other monetary transfers based on a $125 per diem for in-patient hospitalization, and any other rebate, refund, or discount from Humana-Sunrise to Humana Insurance that was 40% or greater of actual billed charges.

Consequently, by Defendants' own admissions, William Larry Cash was the sole living individual associated with Humana and Humana Insurance who was most intimately and directly involved in the ERISA and RICO violations that Defendants committed. Those "new facts" came to light on September 27, 1991, *less than two months ago*. It was those

"new facts," among others, that prompted Plaintiffs to identify William Larry Cash as one of the two key individuals whose acts had injured Plaintiffs.

d. Cherry and Cash Will Not Be Prejudiced

Defendants contend that "[Cherry and Cash] were never placed on notice of any potential individual liability when Plaintiffs filed their earlier pleadings. . . . [T]he action has taken a shape over which [Cherry and Cash] had no control." Opposition at 10.

Defendants have not specified how or in what manner Cherry and Cash might be prejudiced by this amendment. Plaintiffs have merely asserted, without more, that "Cherry and Cash will clearly be prejudiced." *Id.* This Court ought to resist Defendants' invitation to assume some abstract prejudice in the absence of any evidence or argument indicating what prejudice, if any, might accrue.

Defendants have not indicated, for instance, and Plaintiffs cannot imagine, precisely how the "shape" of this litigation might have changed if Plaintiffs had named Cherry and Cash as individual defendants earlier. Every act that Plaintiffs have attributed to Cherry and Cash, Plaintiffs have attributed to the present Defendants as well. In the process of defending Humana and Humana Insurance against those allegations, opposing counsel has effectively defended Cherry and Cash against them as well.

Moreover, Defendants themselves have consistently adopted to position that this litigation is not essentially a dispute over facts at all; it is merely a series of disputes over legal interpretations and applications. Defendants are thereby hoist by their own petards. If this litigation involves merely legal interpretations and not facts, then adding Cherry and Jones as co-Defendants will not affect those disputes in the slightest.

e. Any Additional Delay Is Speculative or Minimal

Defendants contend that "[i]t is manifestly unjust for these individuals now to be joined in litigation already two and a half years old." Opposition at 10. The reason this litigation is "already two and a half years old," however, is that Defendants themselves have managed to delay and prolong this litigation for that length of time, even resorting to stratagems that were sanctioned by this Court. If any prejudice has accrued to Cherry and Cash as a consequence, it is not because Plaintiffs failed to name Cherry and Cash initially; it is because Defendants stalled for two and half years before filing an Answer, stalled in responding to almost every discovery request Plaintiffs issued,[2] stalled by interposing endless and groundless objections to those discovery requests, stalled by filing one meritless motion after another, and otherwise incessantly protracted the course of this litigation.

Similarly, Defendants assert that granting leave to amend "will significantly prolong this action. For example, Cherry and Cash likely will move to dismiss the Third Amended Complaint." Opposition at 11. The specter of an additional Motion to Dismiss is little more than an idle fantasy conjured by counsel for Defendants. Defendants' counsel do not represent the estate of Wendell Cherry, nor do they represent William Larry Cash. In fact, they are almost certainly precluded from representing those individuals due to inher-

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[2] As only the most recent example of Defendants' delaying tactics, three days before Plaintiffs filed this Reply, Defendants served on Plaintiffs their Third Supplemental Response to Plaintiffs' First Request for Production of Documents. That Third Supplemental Response consists of several hundred pages of documents in response to Plaintiffs' Requests Nos. 5, 12, 18, 33, and 37. Plaintiffs had initially requested those documents on November 8, 1989, *over two years ago*. Moreover, this Court ordered Defendants to produce their responses to Requests Nos. 12 and 37 on September 27, 1990—*fourteen months ago*.

ent and pervasive conflicts of interest. Hence they are in no position to fashion imaginary scenarios regarding the litigation strategies that counsel for those two individuals may adopt. More important, those imaginary scenarios are scarcely grounds for denying Plaintiffs the opportunity to pursue valid claims against Cherry and Cash.

Once Plaintiffs have served the Third Amended Complaint, then Cherry and Cash may, of course, file a Motion to Dismiss if they believe one is truly warranted. Most of the legal issues in this litigation, however, have already been ruled on by this Court in response to the voluminous and comprehensive Motions to Dismiss that Defendants have previously filed. Accordingly, any Motion to Dismiss that Cherry and Cash might file would be minimal, and any delay it might occasion would be minimal as well.[3]

The same is true of discovery efforts. A great amount of discovery remains to be completed in this litigation, and Cherry and Cash can readily participate. Plaintiffs, whose discovery requirements are far greater than those of Defendants, have every intention of completing their discovery within the present deadline. Cherry and Cash can certainly do so as well.

Moreover, Plaintiffs assume that Defendants will offer to share with Cherry and Cash the discovery that Defendants have completed to the present; alternatively, Cherry and Cash can readily obtain that discovery from Defendants.

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[3] The only issue Defendants cite that might arise in a Motion to Dismiss by Cherry and Cash is "whether a properly pled RICO conspiracy under § 1962(d) may consist solely of a corporation, its officers, employees or subsidiaries." Opposition at 11 n.5. Plaintiffs resist the temptation to respond to Defendants' arguments concerning that issue *at this time*, and simply observe that it is the *only* issue Defendants have mentioned.

Consequently, rather than finding themselves at a disadvantage in this litigation, Cherry and Cash may well find they have saved countless thousands of dollars in discovery and litigation costs by drawing on the efforts that Defendants have already pursued. Cherry and Cash will be relieved of arguing the numerous legal and technical issues that Defendants have raised during the first two and a half years of this matter, of arguing the numerous motions that Defendants have filed, of drafting the numerous interrogatories, requests for production, and requests for admissions that Defendants have served on Plaintiffs. In the most practical sense, Cherry and Cash may well find they have benefited enormously from the timing of this amendment.

Defendants' other objections are even more groundless. Defendants argue that "the participation of Cherry and Cash as Defendants is not necessary to permit Plaintiffs to pursue their theories of liability." Opposition at 9. The same is true in countless actions involving multiple defendants, yet Plaintiffs are not aware of any restriction on joinder of defendants in this situation to those whose presence is "necessary." Plaintiffs are entitled to name, or not name, any Defendants that Plaintiffs believe are liable for the damages that Plaintiffs incurred.

Defendants then question whether Plaintiffs are engaging in "an improper attempt to facilitate discovery." *Id.* n.4. Plaintiffs, of course, have *no imaginable reason* to facilitate discovery. After all, Defendants have responded so promptly and so completely to all of Plaintiffs' discovery requests that Plaintiffs found it necessary to file only *four motions to compel and two motions for sanctions*. Defendants, moreover, offer no precedent or reasoning for their assertion that facilitating discovery is "improper" or a bad faith reason to amend a complaint. The three decisions Defendants cite, *see id.*, are altogether silent on that issue. In all three of them, moreover, the Ninth Circuit *allowed* leave to amend.

Defendants then question whether Plaintiffs are engaging in "a litigation strategy designed to exert emotional pressure upon the corporate Defendants through active litigation against the Estate." *Id.* Plaintiffs were not aware that corporations even *had* emotions — especially, Plaintiffs are tempted to add, the monolithic corporate Defendants involved in this litigation. This a shabby conjecture for Defendants to advance.

Finally, Defendants have questioned why Plaintiffs are naming "the recently-deceased president of one corporate Defendant," *id.* at 9. Defendants argue: "Plaintiffs have known of the activities of Cherry at all times during this litigation, and waited until Cherry was deceased to name him as a party." *Id.* at 10. Defendants are imputing to Plaintiffs a prescience appropriate only to Mr. Cherry's personal physicians and, one assumes, the Almighty. In truth, the death of Mr. Cherry had no bearing whatever on Plaintiffs' decision, as is evidenced by Plaintiffs' concurrent decision to name William Larry Cash — who was, at last count, still among the living. Plaintiffs do concur in Defendants' assertion that "[t]his loss of access to a potentially vital witness is clearly prejudicial." *Id.* The prejudice, however, is to *Plaintiffs*, not to Defendants. Defendants had countless opportunities to confer with Mr. Cherry regarding these matters during the past two and a half years. Plaintiffs had no opportunities to do so, and now they never will.

4. The Decision in *Reddy* Offers Ample Grounds for Leave to Amend

Plaintiffs have noted that the decision in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991), resolved in Plaintiffs' favor an issue that prevented Plaintiffs from alleging RICO violations of 18 U.S.C. § 1962(d) conspiracy to violate 18

U.S.C. § 1962(a). *See* Motion at 3-4.[4] Plaintiffs had already alleged violations of § 1962(a), and regarded an allegation of *conspiracy* to violate § 1962(a) as entirely duplicative in terms of the damages that Plaintiffs might recover.

Even the decision in *Reddy* was of no more than academic interest to Plaintiffs so long as their § 1962(a) allegations remained intact. On July 9, 1991, however, this Court dismissed those § 1962(a) allegations, on the grounds that Plaintiffs had not demonstrated and could not demonstrate injury from Defendants' use or investment of racketeering income.

At that moment the decision in *Reddy* acquired new and immediate significance to this litigation. *Reddy* now offered Plaintiffs an opportunity to preserve their § 1962(a) claims by alleging *conspiracy* to violate that section, pursuant to 18 U.S.C. § 1962(d).

Hence Plaintiffs had no reason to cite *Reddy*, or to allege violations of 18 U.S.C. § 1962(d), prior to this Court's Order of July 9, 1991 — less than four months before Plain-

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[4] Defendants dispute the holding in *Reddy*, asserting that "[n]o case decided subsequent to *Reddy* supports Plaintiffs' interpretation." Opposition at 7 n.2. That is rather less than surprising, given that the United States Supreme Court denied certiorari in *Reddy* only on October 15, 1991, less than one month before Defendants filed their Opposition.

Defendants then cite three decisions, *Saul v. United States*, 928 F.2d 829 (9th Cir. 1991), *Price v. Hawaii*, 921 F.2d 950 (9th Cir. 1990), and *U.S. Concord, Inc. v. Harris Graphics Corp.*, 757 F. Supp. 1053 (N.D. Cal. 1991). Plaintiffs are at a loss to penetrate Defendants' reasons for those citations. The two decisions from the Ninth Circuit, *Saul* and *Price*, did not involve RICO allegations at all. In the decision from the District Court for the Northern District of California, *U.S. Concord*, the court dismissed RICO claims for reasons having nothing to do with the decision in *Reddy*. In fact, the court's only references to *Reddy* did not even involve the § 1962(d) conspiracy.

tiffs filed their motion for leave to amend. Consequently Defendants' assertion that "Plaintiffs have had nearly sixteen months to advise the Court of the *Reddy* decision, to file an amended complaint with the court, and to seek leave to amend their complaint," Opposition at 7, is misguided at best.

Finally, in one of the very decisions relied on by Defendants, *Sierra Club v. Union Oil of Calif.*, 813 F.2d 1480 (9th Cir. 1987), the Ninth Circuit reversed a denial of leave to amend, holding that "[m]ere delay in proffering an amendment does not justify denying leave to amend." *Id.* at 1493 (citation omitted). "Where a defendant is on notice of the facts contained in an amendment to a complaint, there is no serious prejudice to defendant in allowing the amendment." *Id.* Defendants have not even alleged any prejudice by allowing this aspect of the proposed amendment, and Defendants cannot so allege. They were already on notice as to the facts contained in that amendment.

5. New Facts Have Arisen Concerning Defendants' Obstruction of Justice

During their process of refinement, Plaintiffs discovered evidence of abuses by Defendants that prompted the filing of an entirely new claim for relief, involving obstruction of justice in violation of 18 U.S.C. § 1503. Defendants have attempted to disparage that new claim as "elevating these procedural skirmishes to a substantive criminal offense in this complaint," Opposition at 5 n.1, and as an "attempt to bootstrap discovery disputes into an additional cause of action," *id.* Plaintiffs cannot concede, however, that violations of the Federal Rules of Civil Procedure, the Racketeer Influenced and Corrupt Organizations Act, and a federal criminal statute qualify as mere "procedural skirmishes" or "discovery disputes."[5]

In any event, those allegations are certainly proper for inclusion in the proposed Third Amended Complaint. Defendants have offered no reason, only empty rhetoric, to deny Plaintiffs their opportunity to pursue those claims.

6. Defendants' Other Objections Are Meritless

Defendants contend that Plaintiffs have altered their theories of liability. Defendants cite the portion of Plaintiffs' amended ERISA claims alleging "that Defendants submitted a fraudulent master policy to the Insurance Division of Nevada," Opposition at 17, and assert: "This is a new theory of recovery." *Id.* Defendants have misapprehended that portion of the proposed Third Amended Complaint. Plaintiffs are not pursuing recovery for fraud on the Insurance Division of Nevada, nor have Plaintiffs named the Insurance Division as a new class member. Plaintiffs are merely pursuing, now as before, Defendants' fraud on the Premium-Payor Class. Defendants' submission of the fraudulent master policy to the Insurance Division was simply one aspect of the process whereby Defendants accomplished that fraud.

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[5] Defendants additionally find "anomalous" that Plaintiffs sought to file under seal a Motion for Partial Default involving those allegations, "presumably to avoid impermissible interference with a pending jury trial ongoing in state court," *id.*, yet Plaintiffs did not file their Motion for Leave under seal as well. This Court ought to bear in mind that it was Plaintiffs, not Defendants, who sought to preserve the integrity of that pending trial. And it was Plaintiffs who concluded that integrity was not significantly threatened by minimal references to those allegations buried in a highly technical, 69-page Complaint that was largely incomprehensible to the media. Plaintiffs, moreover, were correct. No mention of those allegations has yet appeared in any media reports, and the jury in that trial returned with its verdict on the very date that Plaintiffs filed the instant Reply.

Defendants contend that "addition of a state RICO claim and federal RICO conspiracy claims to this class action requires a new class certification procedure pursuant to Fed. R. Civ. P.23(c)(1)." Opposition at 16. That is simply erroneous. *The Nevada RICO Premium-Payor and Co-Payor classes will be identical to the federal RICO Premium-Payor and Co-Payor Classes*. Precisely the same issues of numerosity, commonality, typicality, and adequacy are involved as those in regard to the Federal RICO classes — issues that were completely briefed, argued, and ruled on by this Court in certifying those classes. Hence the Court may readily dispose of those issues in certifying Nevada RICO classes. The same is true of Plaintiffs' amended federal RICO conspiracy claims.[6]

Defendants' only other objections to the Nevada RICO claims in Plaintiffs' proposed Third Amended Complaint are that "[t]his state law claim [sic] could have been asserted in Plaintiffs' original complaint. These amendments amount only to shifts in Plaintiffs' legal theories." Opposition at 17. Plaintiffs have not "shifted" their legal theories at all. Plaintiffs have added Nevada RICO claims that, as already noted *supra*, are largely coextensive with Plaintiffs' federal RICO claims.

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[6] In the decision cited by Defendants to argue that additional class notices are necessary, *Matarazzo v. Friendly Ice Cream Corp.*, 70 F.R.D. 556 (E.D.N.Y. 1976), the court was concerned, inter alia, with issues of increased liability of the plaintiffs to third parties caused by the addition of a new claim that characterized the plaintiffs as independent contractors instead of franchisees. That situation does not even remotely arise here. Moreover, the court in *Matarazzo* held that if, at trial, the problem was shown to add no new burdens to the plaintiffs, then they might be granted leave to amend.

IV

CONCLUSION

The United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . *the leave sought should, as the rules require, be "freely given."*

Id. at 182 (emphasis added). Defendants have simply not offered this Court any compelling reason to deny Plaintiffs an opportunity to resolve all of their claims in this litigation at one time, without the necessity for pursuing them in additional actions or in other courts. The prospects of prejudice that Defendants have alleged are abstract and inchoate, without form or substance. The possibility of delay that Defendants have alleged is minuscule compared to the delays that Defendants themselves have already caused. Hence, in accordance with the intent of Fed. R. Civ. P. 15 and the overwhelming authority of precedent, Plaintiffs urge this Court to grant their Motion for Leave to Amend.

DATED this 25th day of November, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
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ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' REPLY TO DEFENDANTS' OPPOSITION TO MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this 25 day of November, 1991.

LIONEL SAWYER & COLLINS
By /s/Louis Garfinkel/DIB
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CERTIFICATE OF MAILING

I hereby certify that on the 25th day of November, 1991, the foregoing PLAINTIFFS' REPLY TO DEFENDANTS' OPPOSITION TO MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

Mark J. Biros, Esq.
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/s/ Jill S. Fletcher
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UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (LRL)

MARY FORSYTH, et al.

Plaintiffs,

vs.

HUMANA, INC., et al.,

Defendants.

ORDER

Before the Court is Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand (#490), filed October 31, 1991. Defendants filed their Opposition (#508) on November 15, 1991. On November 18, 1991, Plaintiffs filed a Notice of Errata in Motion to File Third Amended Complaint (#509). On November 25, 1991, Plaintiffs filed their Reply (#512).

Having read and considered the papers before it, the Court finds that Plaintiffs have failed to demonstrate that the proposed additions to the complaint could not have been included in earlier amendments. Plaintiffs have had numerous opportunities to apprise Defendants and this Court of all purported grounds for relief and any additional parties they to bring before the Court.

IT IS THEREFORE ORDERED that Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand (#490) is denied.

DATED: December 5, 1991

/s/ Philip M. Pro
PHILIP M. PRO
United States District Judge

(7)

AUG 6 1998
OFFICE OF THE CLERK

No. 97-303

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1997

HUMANA INC. AND
HUMANA HEALTH INSURANCE OF NEVADA, INC.,
Petitioners,

v.

MARY FORSYTH, MARIETTA CADE,
WILLIE ANDREWS, MARY LOU BUEHLER,
HELEN STAVES, RANDOLPH BRATTON,
AND SEARLE AUTO GLASS, INC.,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

BRIEF ON THE MERITS OF PETITIONERS

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45 PP

QUESTION PRESENTED

Whether the application of a federal statute -- here the Racketeer Influenced and Corrupt Organizations Act ("RICO") -- to the business of insurance would "invalidate, impair or supersede" state law regulating the same conduct in contravention of the McCarran-Ferguson Act where the state and federal statutory prohibitions are parallel, but the remedies provided are materially different.

PARTIES TO THE PROCEEDING BELOW

1. Humana Inc. ("Humana") and Humana Health Insurance of Nevada, Inc. ("Humana Insurance"), petitioners herein, were defendants in the district court and appellees in the court of appeals. Humana Insurance is a wholly owned subsidiary of Humana. There are no other parent corporations of petitioners and no nonwholly owned subsidiaries; but, by reason of certain contractual obligations undertaken in connection with the acquisition of Humana's former hospital operations subsequent to the events at issue herein, Columbia/HCA Healthcare Corporation is beneficially interested in the outcome of this litigation.

2. Mary Forsyth, Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc., respondents here, were plaintiffs in the district court and appellants in the court of appeals. They were certified by the district court pursuant to Rule 23 of the Federal Rules of Civil Procedure as representatives of the classes described herein.

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In The

SUPREME COURT OF THE UNITED STATES

October Term, 1997

No. 97-303

Humana Inc. and
Humana Health Insurance of Nevada, Inc.,
Petitioners,

v.

Mary Forsyth, Marietta Cade,
Willie Andrews, Mary Lou Buehler,
Helen Staves, Randolph Bratton,
and Searle Auto Glass, Inc.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF ON THE MERITS OF PETITIONERS

REPORT OF OPINIONS BELOW

The opinion of the court of appeals is reported as *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997).

That opinion withdraws and supersedes an earlier opinion of the same court reported as *Forsyth v. Humana, Inc.*, 99 F.3d 1504 (9th Cir. 1996). The opinion of the district court is reported as *Forsyth v. Humana, Inc.*, 827 F. Supp. 1498 (D. Nev. 1993). The decisions of the court of appeals and the district court are found as Appendices A and B, respectively, to the Petition for writ of Certiorari.

JURISDICTION

The decision under review was entered by the court of appeals on May 23, 1997. That decision granted in part a timely motion for rehearing filed by petitioners here respecting an earlier decision entered by the court of appeals on November 5, 1996. This Court has jurisdiction to review the decision at issue by writ of certiorari pursuant to 28 U.S.C. §§ 1254(1) and 2101(c).

STATUTES AT ISSUE

This case addresses principally the interpretation of section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), which provides, in pertinent part:

> "No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance. . . ."

The civil remedy provisions of RICO, 18 U.S.C. §§ 1961-1968 are also implicated by this case. The full text of the McCarran-Ferguson Act is set forth in the Appendix hereto. The pertinent provisions of RICO are set forth in Appendix C to the Petition for Writ of Certiorari.

STATEMENT OF THE CASE

A. Summary of Material Facts and Allegations.

This action arises out of disputes respecting the administration and interpretation of employee group health insurance policies sold by Humana Insurance in the mid-1980's in the State of Nevada. These policies contained a "co-payment" provision pursuant to which patients covered by the policies were obligated to pay all charges up to a specified deductible and to pay 20% of charges above the deductible (up to a specified annual maximum). Humana Insurance was responsible for the remaining 80%. Joint App. at JA-117.

Among other coverages, the policies covered treatment at certain Nevada hospitals, including a hospital owned by Humana, Humana Hospital-Sunrise ("Sunrise"). Appendix A to Petition for Writ of Certiorari at 2a. (114 F.3d at 1472.) Humana Insurance negotiated discounts with Sunrise for hospital services provided to its policy beneficiaries, substantially reducing the costs on many procedures. Record, CR 804, Vol. 8, Nos. 8-10. In administering the co-payment feature of the policies, Humana Insurance credited those discounts entirely to its 80% obligation.

Policy beneficiaries continued to be billed for their 20% of the undiscounted hospital charge. Record, CR 804, Vol. 9, No. 28.

In amendments to its insurance law effective in 1988, Nevada prohibited this practice and required that the benefits of such discounts be applied, *pro rata*, to an insured's co-payment obligation. *See* Nev. Rev. Stat. § 689B.061 (1997). Humana Insurance complied with that change in law and has calculated co-payment obligations accordingly since its enactment. Record, CR 804, Vol. 3, No. 13.

Respondents, on their own behalf and on behalf of a class of policy beneficiaries who made co-payments,[1] have alleged that Humana Insurance misrepresented to its insureds the pertinent facts regarding its method of accounting for discounts during the period when those discounts were credited solely to its 80% obligation. Respondents have further alleged that these misrepresentations were made in the various mailings sent by Humana Insurance to its insureds regarding their co-payment obligations, or in telephone conversations with insureds, and that these communications constitute multiple predicate acts of mail or wire fraud, giving rise to a claim for civil remedies under

[1] This class -- termed the "Co-Payor Class" -- was certified by the district court for purposes of prosecuting this claim on July 9, 1991. Record, CR 364.

RICO (the "Co-Payor RICO Claim").[2] Joint App. at JA-126-JA 131.

B. Pertinent Procedural History.

Petitioners moved the district court for summary judgment on the Co-Payor RICO claim on the ground, *inter alia*, that the application of RICO to the claim processing at issue was barred by section 2 of the McCarran-Ferguson Act.

The district court held that RICO was subject to the limitations of the McCarran-Ferguson Act, that the conduct alleged was part of the business of insurance and that the conduct was subject to Nevada's comprehensive regulatory scheme governing the business of insurance in that state which reserves to the Nevada Commissioner of Insurance "exclusive jurisdiction" in regulating the trade practices of

[2] In addition to this claim for relief, respondents also asserted three additional claims below: (1) a claim under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461; (2) a claim under the Sherman Act, 15 U.S.C. §§ 1-7; and (3) a RICO claim for a class of the employers who bought the policies (the "Premium Payor Class"). As noted in the Petition for Writ of Certiorari (p.4 n.1 and p.5 n.2), the opinions below address all three claims, but only the Co-Payor RICO claim is at issue here.

the insurance industry and which contains numerous provisions addressing, and prohibiting, deceptive conduct in the sale or administration of policies. Appendix B to Petition for Writ of Certiorari at 91a-97a. (827 F. Supp. at 1520-21.) The district court also concluded that application of RICO to those practices would impair Nevada's regulatory scheme because RICO's civil penalties -- principally its treble damage provision -- far exceed the penalties proscribed by the State of Nevada for the same conduct. Appendix B to Petition for Writ of Certiorari at 95a. (827 F. Supp. at 1521-22.) On this reasoning, the district court granted summary judgment on the Co-Payor RICO claim.

On appeal, the Ninth Circuit reversed the district court on this issue. The court of appeals agreed with the district court's determination that the conduct at issue was the business of insurance, that Nevada regulated the conduct and that RICO was subject to the limitations of the McCarran-Ferguson Act. Appendix A to Petition for Writ of Certiorari at 22a-25a. (114 F.3d at 1479-80.)[3] The court of appeals did not agree, however, that the application of RICO would impair Nevada's regulatory scheme. Relying upon its then recent decision in *Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486 (9th Cir. 1995), the court of appeals held that the disparity in remedies between

[3] The Ninth Circuit's affirmance on these three points is not within the question presented and, hence, is not at issue here and will not be addressed further in this brief.

RICO and Nevada insurance law did not create a conflict between federal and state law sufficient to preclude plaintiffs' RICO claim.[4] Appendix A to Petition for Writ of Certiorari at 25a-26a. (114 F.3d at 1480.)

Petitioners sought review of this decision by certiorari, presenting as the sole question for review whether the Ninth Circuit erred in concluding that the material differences in

[4] In discussing Nevada remedies, the Ninth Circuit recites in the decision below that Nevada law affords no private remedy to insureds for deceptive claims processing practices by insurers, a proposition that the United States questions at p. 19 of the Brief of the United States as Amicus Curiae, filed in connection with the petition for certiorari. In fact, the applicable Nevada statute changed during the relevant time period. Prior to 1987, Nev. Rev. Stat. 686A.310, contained no provision for a private cause of action. In a 1987 amendment, Nevada added subpart (2) to this statute, expressly granting such a private cause of action. The federal district court for the District of Nevada has held that this amendment simply reaffirmed existing law and that a private cause of action existed by implication even prior to the amendment -- *see Crystal Bay Gen. Improvement Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1376-77 (D. Nev. 1989) -- but there is no reported Nevada decision to that effect, and such a conclusion seems inconsistent with the provisions reserving to the Commissioner "exclusive jurisdiction" over insurance industry trade practices.

remedies between RICO and Nevada law did not implicate the McCarran-Ferguson Act. On June 22, 1998, this Court issued the writ requested.

SUMMARY OF ARGUMENT

As noted in the Petition for Writ of Certiorari, the decision below is one of numerous conflicting decisions of the several circuits respecting the interpretation of the McCarran-Ferguson Act generally, and of its applicability to RICO specifically. That split among the circuits is reflective of a basic difference in jurisprudential approaches to the issue at hand. The Ninth Circuit, like other circuits rejecting the proposition that the McCarran-Ferguson Act precludes the application of RICO to the business of insurance, uses an "inverse preemption" analysis that applies to the McCarran-Ferguson analysis the strict "direct conflict" rules that are frequently applied in cases involving implied federal preemption of state law.[5] *Merchants Home Delivery Serv.,*

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[5] This test for McCarran-Ferguson Act preclusion was first espoused by the Seventh Circuit in *NAACP v. American Family Mutual Insurance Co.*, 978 F.2d 287, 296-97 (7th Cir. 1992), a case that did not involve RICO. Other decisions embracing it include *Sabo v. Metropolitan Life Insurance Co.*, 137 F.3d 185, 194-95 (3d Cir. 1998); *Villafane-Neriz v. FDIC*, 75 F.3d 727, 735-36 (1st Cir. 1996); and *Nationwide Mutual Insurance Co. v. Cisneros*, 52 F.3d 1351, 1360-63 (6th Cir. 1995), *cert. denied*, 516 U.S. 1140 (1996).

Inc. v. Frank B. Hall & Co., supra, 50 F.3d at 1492. The circuits finding McCarran-Ferguson preclusion have not constrained their analysis by the special restrictive rules applicable to implied federal preemption. Instead, these courts have examined the question of whether the McCarran-Ferguson Act applies to RICO using generally applicable principles of statutory interpretation.[6]

The "inverse" preemption analysis embraced by the Ninth Circuit below is logically flawed. The restrictive implied federal preemption rules of construction are predicated upon principles of federalism and reflect the strong presumption that the laws of the states are to be preserved, despite overlapping federal legislation. *See, e.g., Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992). The McCarran-Ferguson Act does not involve federal interference in state regulation, but rather Congress' voluntary withdrawal from a field seen best left to the states.

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[6] *Doe v. Norwest Bank Minnesota, N.A.*, 107 F.3d 1297, 1305-08 (8th Cir. 1997); *Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384, 391-93 (6th Cir. 1996); *Ambrose v. Blue Cross & Blue Shield*, 891 F. Supp. 1153, 1159, 1165-68 (E.D. Va. 1995), *aff'd mem.*, 95 F.3d 41 (4th Cir. 1996) (unpublished memorandum). The Fourth Circuit's affirmance of *Ambrose* appears to reject its earlier and arguably contrary *dictum* in *Mackey v. Nationwide Insurance Cos.*, 724 F.2d 419 (4th Cir. 1984).

Adoption of an "inverse preemption" analysis has the perverse result of applying a rule of construction created out of a concern for states' rights to circumscribe a statute that is intended to foster those same rights.

The ordinary rules of statutory interpretation should be applied to the McCarran-Ferguson Act. Under those rules, the McCarran-Ferguson Act must be interpreted as precluding the application of RICO to the business of insurance. The language and history of the statute bespeak a broad preclusionary intent, not limited to "direct conflicts," but intended to withdraw Congress from the field absent an express congressional statement to the contrary. A federal statute that imposes materially different remedies or procedures than does an otherwise parallel state law effectively renders superfluous the state legislative decisions respecting those remedies or procedures. Accordingly, the application of such a statute to the business of insurance would "invalidate, impair or supersede" state law in derogation of the McCarran-Ferguson Act even if the federal law and the state law were parallel with respect to their substantive prohibitions.

ARGUMENT

The McCarran-Ferguson Act was the congressional response to this Court's decision in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), which overturned a long-standing presumption that the sale of insurance was not commerce and, hence, was not reached by federal law regulating interstate commerce. *See, e.g., Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183 (1869). As a consequence of *South-Eastern*, state laws on insurance, which had been thought to be the exclusive source of regulation, were threatened with eclipse by federal law which, if applicable at all, becomes ascendant under the supremacy clause. The McCarran-Ferguson Act was specifically intended to prevent that result. *Department of Treasury v. Fabe*, 508 U.S. 491, 500 (1993).

The federal legislation at issue in *South-Eastern* was the Sherman Act, 15 U.S.C. §§ 1-7. Not surprisingly, therefore, most of the congressional debate on the Act centered on its effect on the antitrust laws, which proved to be the most contentious aspect of the legislation.[7] The

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[7] The remarks of Senator Pepper are illustrative:

> "I do not oppose State regulation which is not inconsistent with the operation of the Sherman Antitrust Act and the Clayton Act. On matters of taxation, general regulation, and all that sort of thing,

McCarran-Ferguson Act is not limited to the antitrust laws, however, and provides a rule of general applicability to all federal legislation, except for the statutes enumerated in section 4 of the Act and federal legislation related specifically to insurance.[8] On this issue, there appears to be no disagreement among the circuits, and the Ninth Circuit expressly acknowledged below that the McCarran-Ferguson Act would preclude the application of RICO to the insurance practices at issue if RICO could be said to invalidate, impair or supersede Nevada law regulating the conduct. Appendix A to Petition for Writ of Certiorari at 22a. (114 F.3d at 1480.)

Where the circuits diverge is on the issue of the test to apply in making the "invalidate, impair or supersede" determination. The Eighth, Sixth and (apparently) Fourth

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> I think the States should regulate, but I think that now that insurance has been brought, by the decision of the Supreme Court, up to the bar of the Clayton Act and the Sherman Act, we should not give the insurance companies immunity from the applicability of those acts."

91 Cong. Rec. 1444 (1945).

[8] This Court itself applied the McCarran-Ferguson Act to the bankruptcy laws in *Department of Treasury v. Fabe*, *supra*, 508 U.S. at 493, 508-510.

Circuits apply a broad rule of McCarran-Ferguson preclusion derived from the breadth of the language of the statute. On their reading of the Act, those circuits have concluded that material differences between state and federal law on remedies alone may result in preclusion of the federal law. *See, e.g., Doe v. Norwest Bank Minnesota, N.A., supra*, 107 F.3d at 1307-08. In contrast, the Ninth Circuit, and the circuits that share its view, apply a narrow rule derived from an "inverse preemption" analysis that reasons that McCarran-Ferguson preclusion of federal law in deference to state law is analogous to implied federal preemption of state law and should be governed by the same rules. On this reasoning, these circuits require a "direct conflict" between state and federal law, a conflict that they do not find in differences in the procedures or remedies provided by state and federal law. *See, e.g., Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co., supra*, 50 F.3d at 1492.

The conclusion reached by the Ninth Circuit and the others adopting this analysis is not free from doubt even if the "inverse preemption" analysis used were otherwise appropriate. In concluding that even material differences in procedures or remedies would not be a "direct conflict" sufficient for implied federal preemption, the Ninth Circuit relies on *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238 (1984). In *Silkwood*, however, this Court made note of the fact that the legislative history of the federal statute in question showed a congressional intent to preserve the state tort remedies at issue. 464 U.S. at 251-56. This Court has

elsewhere found a difference in remedies to be sufficient state interference with federal law to require preemption. *E.g.*, *Garner v. Teamsters*, 346 U.S. 485, 498-99 (1953); *San Diego Bldg. Trades Council v. Garmon*, 359 U.S. 236, 247 (1959). Moreover, if a federal preemption analysis were to be adopted for application of the McCarran-Ferguson Act, the "field" preemption of *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947) would appear to be the better analogy given the statutory structure and legislative history that demonstrates the congressional intent to leave the entire field of insurance regulation to the states.[9]

The principal flaw in the Ninth Circuit's reasoning below is not, however, in the *manner* in which the court applied the law of implied federal preemption. Rather, it is in the determination that those rules properly apply to the McCarran-Ferguson Act at all. As will be discussed in the balance of this brief, they do not. The ordinary rules of statutory interpretation apply and they compel the opposite of the determination reached by the Ninth Circuit below.

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[9] The remarks of Representative Gwynne, one of the principal proponents of the Act in the House of Representatives, most clearly make the point:

> "What we are trying to do is to make it clear to the States and to the insurance companies that we are as far as possible removing ourselves from the field."

91 Cong. Rec. 1090 (1945).

A. The "Inverse Preemption" Analysis Underpinning the Decision Below Is Inappropriate for Application of the McCarran-Ferguson Act.

One can hardly quarrel with the observation that McCarran-Ferguson preclusion of federal law has an effect that is analogous to federal preemption of state law. It does not follow, however, that the two must, or should, be governed by the same rules. Given that the "direct conflict" test has no basis in the language of the statute, whether federal preemption rules should apply to a McCarran-Ferguson analysis depends upon whether application of those rules would foster the goals of the Act. Examination of that question -- which is not addressed in the decisions of the Ninth Circuit or of the other circuits sharing its view -- quickly leads to the conclusion that the application of rules governing issues of federal preemption fosters not merely different goals than the McCarran-Ferguson Act, but totally contrary goals.

The restrictive rules governing federal preemption are predicated upon principles of federalism. *Community Communications Co. v. Boulder*, 455 U.S. 40, 61 (1982) (Rehnquist, J., dissenting). They reflect the structure of our Constitution, in which the powers of the federal government "are few and defined [while those] which are to remain in the State governments are numerous and indefinite." *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991) (*quoting* The Federalist No. 45, at 292-93 (James Madison) (Clinton Rossiter ed. 1961)). A strong presumption is applied that

state laws are to be preserved if possible, despite overlapping federal legislation. *E.g.*, *Cipollone v. Liggett Group, Inc.*, *supra*, 505 U.S. at 516.

Simply put, the goal served by the rules of implied federal preemption is deference to the sovereignty of the states. When these rules are applied in the "inverse" case of McCarran-Ferguson preclusion, as the Ninth Circuit does, their effect is itself inverted, with the rules now fostering the goal of deference to *federal* sovereignty.

No federalist principle requires such a rule since McCarran-Ferguson preclusion is a voluntary relinquishment of power by Congress and not a result forced upon the federal government by a clash of sovereignties. Under the supremacy clause, federal law prevails in such a clash in any event, a circumstance that further illustrates the inappropriateness of using a principle of interpretation intended to protect the subservient sovereign. While the states can do nothing about federal laws that preempt their own, Congress need only state that a federal statute applies to insurance to avoid the preclusive effect of the McCarran-Ferguson Act.

More to the point, limiting McCarran-Ferguson preclusion by applying a rule of strict deference to federal sovereignty would run directly contrary to the goals of the Act, which this Court itself has characterized as restoring "the supremacy of the States in the realm of insurance regulation." *Department of Treasury v. Fabe*, *supra*, 508

U.S. at 500. Use of an "inverse preemption" analysis frustrates, not fosters, the purposes of the McCarran-Ferguson Act.

Use of an "inverse preemption" analysis is also inconsistent with the language and history of the Act. An "inverse preemption" test necessarily limits the preclusive effect of the McCarran-Ferguson Act to circumstances in which, but for the Act, the federal statute in question would preempt the state statute. Such a limitation would reduce the "invalidate, impair or supersede" formulation of the Act to simply "invalidate," leaving "impair or supersede" without meaning or effect in violation of the interpretive principle that, when words are used in the disjunctive, each must be given its separate meaning. *Garcia v. United States*, 469 U.S. 70, 73 (1984).

An "inverse preemption" analysis also includes -- indeed, is predicated upon -- the presumption that all federal legislation applies to the business of insurance. Only where it can be shown that it is impossible to apply federal law without directly conflicting with state law would the application of federal law be precluded by the Act. The structure of the McCarran-Ferguson Act is not consistent with such a presumption since the Act places upon Congress the burden of deciding whether it wants legislation to apply to insurance and imposes the presumption that it does not "unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b) (1994). That this structure reflects a congressional intent that the opposite presumption

apply -- *i.e.*, that federal law be presumed *inapplicable* to insurance -- is made unambiguously clear in legislative history quoted and relied upon by this Court in *Fabe*:

> "What we have in mind is that the insurance business, being interstate commerce, if we merely enact a law relating to interstate commerce, or if there is a law now on the statute books relating in some way to interstate commerce, it would not apply to insurance. We wanted to be sure that the Congress, in its wisdom, would act specifically with reference to insurance in enacting the law."

Department of Treasury v. Fabe, *supra*, 508 U.S. at 507 n.7 (*quoting* 91 Cong. Rec. 1487 (1945) (statement of Sen. Ferguson).[10]

This Court has had numerous occasions to address the interpretation of other provisions of the McCarran-Ferguson Act over the years, most recently in *Barnett Bank, N.A. v. Nelson*, 517 U.S. 25 (1996). On each occasion, it has approached the issue using the ordinary rules of statutory interpretation:

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[10] Representative Gwynne made similar remarks in the House:

> ". . . no act of Congress governing interstate commerce shall apply to insurance unless the act specifically so states."

91 Cong. Rec. 1090 (1945).

> "[T]he starting point in a case involving construction of the McCarran-Ferguson Act, *like the starting point in any case involving the meaning of a statute*, is the language of the statute itself."

Department of Treasury v. Fabe, *supra*, 508 U.S. at 500, *quoting Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210 (1979) (emphasis added).[11] It is this traditional approach that should be applied here as well, and that approach requires reversal of the decision under review.

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[11] Contrary to the suggestion of the Third Circuit in *Sabo v. Metropolitan Life Insurance Co.*, *supra* 137 F.3d at 194, *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969) does not provide support for a restrictive approach to McCarran-Ferguson Act interpretation. As the Eighth Circuit correctly noted in *Doe v. Norwest Bank Minnesota, N.A.*, *supra*, 107 F.3d at 1307, *National Securities* is inapposite because this Court's decision there turned on the issue of whether sale or issuance of securities was the "business of insurance" and on the fact that the state and federal statutes at issue were regulating different conduct and were intended to protect entirely different interests.

B. RICO's Materially Different Remedies "Impair or Supersede" Nevada's Otherwise Parallel Insurance Law.

1. *The Language of the McCarran-Ferguson Act Compels the Conclusion That It Bars RICO'S Application To the Business of Insurance.*

The critical interpretive question presented is the meaning of "invalidate, impair or supersede" as used in the Act. Interpretation must begin with the words themselves, as this Court has often cautioned. All of the words must be considered, *Garcia v. United States*, *supra*, 469 U.S. at 73, and the words must be given their ordinary English meaning. *Barnett Bank, N.A. v. Nelson*, *supra*, 517 U.S. at 38-39.

As already noted, "invalidate" could be equated with "preempt" and limited to the narrow circumstance of a conflict between state and federal law so severe as to qualify for federal preemption but for the Act. "Impair" and "supersede" cannot be so constrained, and Congress could not have intended so restrictive a meaning when the Act was passed. As reflected in the leading dictionaries of the time, "impair" is to "make worse, less valuable, or weaker;" or "to diminish in quantity, value, excellence, or strength." OXFORD ENGLISH DICTIONARY 72 (1933); WEBSTER'S NEW INTERNATIONAL DICTIONARY 1246 (2d Ed. 1934). "Supersede" is "to make unnecessary or superfluous," or "to force out of use as inferior." WEBSTER'S NEW

INTERNATIONAL DICTIONARY 2533 (2d Ed. 1934). Any federal statute that lessens the force or significance of a state statute, or renders that statute superfluous, "impairs or supersedes" that state statute. Such a result can follow as readily from a disparity in state and federal remedies as from a disparity in substantive prohibitions.

A regulatory scheme necessarily has three components: (i) substantive prohibitions or mandates; (ii) remedies for non-compliance; and (iii) procedural means for determining compliance and imposing the remedies. Each of these three components is found in the law of Nevada regulating insurance and in that of all the other states as well. Each of these components was the subject of legislative consideration by Nevada and the other states, and nothing in the McCarran-Ferguson Act limits the preclusionary effect of that Act to only the first of these three components. By its terms, the Act also precludes the application of any federal statute (other than those specifically related to insurance) that "impairs" or "supersedes" state law governing the remedies or enforcement procedures included in state insurance regulation.

It is not a sufficient response to this point to suggest, as have some courts, that a disparity in remedies may be supportive of state law if the more potent federal remedies offer a greater chance "that a state norm will be vindicated . . . ." *NAACP v. American Family Mut. Ins. Co.*, *supra*, 978 F.2d at 295. The McCarran-Ferguson Act does not contain any provision for balancing a federal

statute's impairment of state law on remedies against that federal statute's supposed enhancement of the state law's substantive prohibitions or mandates.

Nor is there any basis for assuming, as this argument implicitly does, that state legislative decisions regarding remedies and procedures are less reflective of policy choices than are the decisions on substantive prohibitions.[12] Indeed, such an assumption is contrary to well-established principles of law requiring deference to legislative determinations respecting remedies, and procedures for imposing remedies, in other contexts.

The doctrines of exhaustion of administrative remedies and primary jurisdiction, for example, are grounded in the recognition that a legislative determination to have disputes determined by administrative bodies with accumulated experience and expertise in the applicable area of the law can be as significant as the decision to enact the substantive regulations themselves. *See, e.g., San Diego Bldg. Trades Council v. Garmon, supra* 359 U.S. at 244-45. As regards the scope of the remedies themselves, this Court has recognized that congressional determinations as to the appropriate remedy are entitled to as much respect as the

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[12] The Brief for the United States As Amicus Curiae, filed in connection with the Court's consideration of the petition for certiorari, makes this argument explicitly at page 16, note 10. No authority is cited, however, to support the argument.

determinations regarding substantive mandates or prohibitions and to just as much protection from state interference. As the Court has observed in the context of the federal labor laws, for example:

> "It was precisely the realization that disparities in remedies and administration could produce substantial conflict, in the practical sense of the term, between the relevant state and federal regulatory schemes and that this Court could not effectively and responsibly superintend on a case-by-case basis the exertion of state power over matters arguably governed by the National Labor Relations Act that impelled the somewhat broader formulation of the pre-emption doctrine in *Garmon*."

Amalgamated Ass'n of Street Elec. Ry. & Motor Coach Employees v. Lockridge, 403 U.S. 274, 294-95 (1971); *see San Diego Bldg. Trades Council v. Garmon, supra*, 359 U.S. at 245.

Why should the decisions of the Nevada legislature respecting remedies under its insurance law be given less dignity than Congress' decisions on remedies under the labor laws, particularly where it is plain that Nevada has, in fact, made a policy decision against adopting the very remedies at issue, as evidenced by its own "little RICO" statute. Nev. Rev. Stat. § 207.350-207.520 (1997). As the district court noted below, Nevada's statute allows the same treble damage remedy as RICO. Nev. Rev. Stat. § 207.470. The enumeration of predicate acts (contained in § 207.360)

includes provisions of Nevada's insurance law prohibiting fraud by the insured (§§ 686A.290 and 686A.291) but not the provisions prohibiting fraud *by the insurer*, (*e.g.*, §§ 686A.020, 686A.030 and 686A.040), evidencing an intent by the legislature that RICO remedies not apply to the conduct here at issue. Appendix B to Petition for Writ of Certiorari at 95a, n.33. (827 F. Supp. at 1522 n.33.)

Good reasons exist for rejecting draconian remedies. Such remedies may, for example, drive up the cost of premiums for other policy holders or, in an extreme case, render a carrier insolvent or otherwise impair its ability to honor its coverage obligations to its policy holders. Whether the state's reasons for its decision regarding remedies are good or bad is beside the point, however. Whatever the reasons, the McCarran-Ferguson Act requires that the decision be respected.[13]

This is not to say that trivial disparities in remedies or procedures need result in McCarran-Ferguson preclusion, but the disparities between RICO's remedies and those traditionally found in the law are hardly trivial. See *H.J. Inc. v. Northwestern Bell Tel. Co.*, 492 U.S. 229, 233

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[13] It is telling that the views of the state courts that have considered the issue are in accord that a disparity in remedies does impair or supersede state law. *See American Int'l Group, Inc. v. Superior Court*, 285 Cal. Rptr. 765, 767-68 (Ct. App. 1991); *Leckey v. Aetna Cas. & Sur. Co.*, 590 A.2d 1255, 1260 (Pa. Super. Ct. 1991).

(1989) (RICO's civil remedies are "drastic"). For this reason *every* reported case that examines the question of whether RICO impairs or supersedes state law -- other than the decisions adopting the restrictive "inverse preemption" analysis -- reaches the conclusion that it does. *See Doe v. Norwest Bank Minnesota, N.A., supra*, 107 F.3d at 1306-08; *Kenty v. Bank One, Columbus, N.A., supra*, 92 F.3d at 392; *Ambrose v. Blue Cross & Blue Shield, supra*, 891 F. Supp. at 1165-68; *Everson v. Blue Cross & Blue Shield*, 898 F. Supp. 532, 544 (N.D. Ohio 1994); *Wexco Inc. v. IMC, Inc.*, 820 F. Supp. 194, 203-04 (M.D. Pa. 1993); *LeDuc v. Kentucky Cent. Life Ins. Co.*, 814 F. Supp. 820, 829 (N.D. Cal. 1992); *Richhart v. Metropolitan Life Ins. Co.*, No. 89-1725, 1990 U.S. Dist. LEXIS 3597, at *6-7 (E.D. Pa. March 30, 1990); *Senich v. Transamerica Premier Ins. Co.*, 766 F. Supp 339, 341 (W.D. Pa. 1990).

2. *The History and Purpose of the McCarran-Ferguson Act Further Support the Conclusion That It Bars RICO's Application to the Business of Insurance.*

The interpretation that disparity in remedies and procedures "impairs or supersedes" state law also finds support in the purpose and history of the McCarran-Ferguson Act. As already noted, the Act was a response to *South-Eastern* and an attempt, with limits, to turn the clock back to the time when the states were the sole regulators of the

business of insurance. What conduct was allowed or prohibited was exclusively the province of the states, and so too were the remedies afforded for violation of the norms set by the states. As both the Senate and House reports on the bill that was to become the Act noted: "From its beginning the business of insurance has been regarded as a local matter, to be subject to and regulated by the laws of the several States." S. Rep. No. 79-20, at 1 (1945); H.R. Rep. No. 79-68, at 1 (1945). The purpose of the Act was restoration of that state control, and there is nothing in the Act or its history that suggests that Congress did not intend that control to include control over remedies.

The debates on the floor of Congress are consistent with this interpretation. Various remarks of Senators Ferguson and Pepper and of Representative Gwynne have already been noted above. There are many others to the same effect.[14]

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[14] Apt examples can be found at: 91 Cong. Rec. 481 (1945) (statement of Sen. Ferguson): ". . . Congress did not want at the present time to take upon itself the responsibility of interfering with the taxation of insurance or the regulation of insurance."); 91 Cong. Rec. 483 (1945) (statement of Sen. O'Mahoney): "Section 2(b) . . . [is] a sort of catch-all provision to take into consideration other acts of Congress [other than the antitrust laws] which might affect the insurance industry, but of which we did not have knowledge at the time."); 91 Cong. Rec. 485 (1945) (statement of Sen. Revercomb) (defending the Act against amendment): "Why not let the provision stand that

Except for the exemption from the antitrust laws provided by the Act -- ironically its main application to date -- the debates show a nearly unanimous sentiment to leave the business of insurance entirely to the States.

In sum, the language, purpose and history of the McCarran-Ferguson Act all demonstrate a congressional intent that the preclusive effect of the Act be broadly applied. None support the distinction between remedies and substantive prohibitions that the Ninth Circuit has embraced, and without which the decision below cannot stand.

CONCLUSION

For the foregoing reasons, the decision of the United States Court of Appeals for the Ninth Circuit should be reversed insofar as that decision addressed the Co-Payor RICO claims. This action should be remanded with

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it [future federal legislation] shall not apply unless Congress specifically says in an act that it shall apply to the business of insurance, which we are now trying to return to the States?"); and 91 Cong. Rec. 1442 (1945) (statement of Sen. McCarran): ". . . we give to the States no more powers than those they previously had [before *South-Eastern*], and we take none from them.").

instructions that the court of appeals should affirm the summary judgment granted on that claim by the district court in favor of petitioners.

August 6, 1998

Respectfully submitted,

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APPENDIX

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APPENDIX

Appendix
McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015

APPENDIX

§ 1011. Declaration of policy

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C. 41 et

seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

§ 1013. Suspension until June 30, 1948, of application of certain Federal laws; Sherman Act applicable to agreements to, or acts of, boycott, coercion, or intimidation

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act [15 U.S.C. 41 et seq.], and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act or boycott, coercion, or intimidation.

§ 1014. Effect on other laws

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act [29 U.S.C. 151 et seq.], or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938 [29 U.S.C. 201 et seq.], or the Act of June 5, 1920, known as the Merchant

Marine Act, 1920 [46 App. U.S.C. 861 et seq. and 911 et seq.]

§ 1015. "State" defined

As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam, and the District of Columbia.

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No. 97-303

In The

Supreme Court of the United States

October Term, 1997

HUMANA, INC., and
HUMANA HEALTH INSURANCE OF NEVADA, INC.,

Petitioners,

v.

MARY FORSYTH, MARIETTA CADE,
WILLIE ANDREWS, MARY LOU BUEHLER,
HELEN STAVES, RANDOLPH BRATTON,
and SEARLE AUTO GLASS, INC.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF ON THE MERITS FOR RESPONDENTS

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QUESTION PRESENTED

Whether RICO's authorization of treble damages and counsel fees for a "pattern" of insurance fraud "invalidates, impairs, or supersedes" Nevada's insurance regulatory scheme and Nevada's criminal and civil racketeering statutes under the McCarran-Ferguson Act.

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STATUTES AT ISSUE

This case concerns the Racketeer Influenced and Corrupt Organizations Act (RICO) 18 U.S.C. § 1951 et seq., and Section 2(b) of the McCarran-Ferguson Act (MFA), 15 U.S.C. § 1012(b). Relevant portions of RICO and the MFA are included within Appendix C of Humana's Petition for Writ of Certiorari.

STATEMENT OF THE CASE

A. Factual Background

In the early 1980's, Humana created Humana Insurance as a marketing "strategy to bolster Humana's market share in the new health care environment, in which fewer people are becoming hospital patients" and to "diminish an industry-wide reduction in census." CR 822, Ex. 48 (1986 Humana Annual Report, pp. 12-13).[1] Humana sought tens of millions of dollars in co-payments from patients requiring hospitalization to offset the "incremental cost" of otherwise empty hospital beds. The fantastic financial success of the scheme is demonstrated by the dramatic increase in the **combined** profits of the hospital and the insurer from $14,727,000 in 1985, to $23,053,350 in 1987, to $23,878,050 in 1988 and to $30,991,777 in 1989--a total profit increase of $33,741,103 in 1987 to 1989. JA-207.

---

[1] Another Annual Report explained the "strategy to strengthen the hospital business has been to offer [Humana] insurance . . . thereby **directing patients into our hospitals**." CR 822, Ex. 79 (1988 Humana Annual Report), (emphasis added).

Under its group health insurance agreements, Humana Insurance agreed to pay 80% of the employees' hospital charges and the Co-Payors were obligated to pay the remaining 20%. JA-35. Unknown to the Co-Payors, Humana Insurance negotiated a discount with Humana Hospital Sunrise whereby Humana Insurance paid significantly less than its 80% co-pay share and the Co-Payors paid significantly more than the promised 20% copayment.[2] The secret discount varied during the class period but averaged 89%.[3] The difference between the 89% secret hospital discount that Humana Insurance got and the average 43.4% discounts that Humana Hospital gave to other group health insurers provided Humana Insurance $20,282,574.00 in illicit profit. JA-146.

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[2] The average charge for four days hospitalization was $5,000, making a 20% patient Co-Payor charge $1,000. After the secret discount, Humana Insurance paid only $550 -- not $4,000. CR 912 (7/21/93 Order, p. 19). The "incremental" cost to hospitalize a Co-Payor for one day was just $125. JA-181 Humana's Chairman correlated empty hospital beds to empty airline seats--if either is not used fixed costs remain--making the "incremental cost" of servicing the last passenger (or patient) minimal and the profit very high. CR 822, Ex. 96. **The $1,000 payment by the Co-Payor alone was double the entire $500 incremental cost of the four day hospitalization**; ensuring a healthy profit over the incremental cost without any payment from Humana Insurance.

[3] The discount started at 40% in early 1985, increased to 48% in late 1985, increased to 55.7% in early 1986 and then **retroactively** increased to 89.1% after year end 1986. JA-145, 146

During the four year class period, 30,597 Co-Payors used Humana Hospital and made co-payments to it. CR 822, Ex. 93. Humana sent each one of them an Explanation of Benefits ("EOBs") that falsely represented that Humana Insurance had paid 80% of the same bill that the Co-Payors paid.[4] Key Humana Insurance executives conceded that the contractual language "The Company will pay 80 percent of the covered expenses" was misleading. CR 822, Ex. 7.

The fraudulent billing scheme was a closely guarded secret: "[W]e never told [the Co-Payors] about any discount the hospital was giving to the insurance company that the insured would not get . . . ." CR 822, Ex. 6. Humana even concealed the scheme from its billing agent--Mutual Administrators, from its own insurance sales staff and from

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[4] EOBs explain hospital billings. In this actual EOB, Humana Insurance falsely claims that it "paid" 80% of the full charges:

MAJOR MEDICAL EXPENSES COVERED:
PAYMENT DETERMINATION SUMMARY:

17.00 @ 80.00% =	$13.60
TOTAL PAID:	$13.60
BENEFITS PAYABLE TO:	
Humana Hospital Sunrise	$13.60
TOTAL PAID:	$13.60.

(CR 822, Ex. 33)

80% of the gross charge ($13.60 above) was "paid" by check from Humana Insurance to Humana Hospital. After the secret discount was transferred back, Humana Insurance actually expended $1.87 (11% of the $17 charge), less than the $3.40 paid by the Co-Payor.

regional hospital administrators – who all thought the co-payment was based upon discounted charges.[5] Other Nevada health care insurers, e.g., Blue Cross, passed along negotiated hospital discounts to their Co-Payors. CR 822, Ex. 55.

To prevent discovery by governmental regulators, Humana Insurance pretended to "pay" the non-discounted hospital charges by writing checks to Humana Hospital. CR 927, Ex. 3 at pp. 84, 550-51. For years, Humana Hospital then remitted the secret discount to Humana Insurance through monthly inter-company ledger transfers. CR 822, Ex. 40 at pp. 41-42. When the billing fraud was finally exposed by the media in 1987, Humana issued a press release falsely claiming that the Co-Payors had only been billed discounted charges. CR 822, Ex. 24. The District Court found that Humana Insurance "specifically intended to mislead or deceive Plaintiffs" by agreeing to 80%/20% payments on hospital bills while, in reality,

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[5] Mutual Administrators did the hospital billings for Humana but was not told about the secret discounts. CR 822, Ex. 19. The Humana Insurance VP responsible for the national sales force was not told of the co-payment scheme. CR 822, Ex. 7. The first Nevada insurance sales manager erroneously believed that the co-payment was calculated on the discounted hospital charges. CR 822, Ex. 13. The leading insurance salesman first learned that the Co-Payors did not get discounts from a 1987 newspaper article exposing the billing fraud. CR 822, Ex. 14. Even Humana Hospital's Assistant Regional Manager for the Pacific Regional office (including Las Vegas) was tricked into believing the co-payments were based on discounted charges. CR 822, Ex. 16.

Humana Insurance negotiated a secret 89% discount from Humana Hospital for itself and no discount whatsoever for the Co-Payor Class. CR 912 (7/21/93 Order, 44, 45).

The Attorney General of the State of Nevada commenced an investigation of the billing fraud and prepared a draft criminal complaint that alleged that the co-payment billings in 1986 were violations of the Nevada state racketeering laws.[6] Deputy Attorney General Barlow specifically testified that the billing fraud was encompassed by the Nevada RICO statute.[7] Over Barlow's strenuous objections, Humana short-circuited the criminal case by persuading the Insurance Commissioner to execute a consent degree that imposed a paltry $50,000 fine on Humana and eliminated the proposed criminal RICO charges without refunding one red cent to any defrauded Co-Payor.[8] Respondents vehemently dispute the position of

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[6] CR 182 (Plaintiffs' Filing Of Supplemental Exhibit In Opposition To Defendants' Motion To Dismiss filed on April 27, 1990, Deposition of Deputy Attorney General Gregory Barlow, Ex. 9). "Count V - Racketeering," alleged that Humana Hospital and Humana Insurance "conduct[ed] directly and indirectly, the affairs of the enterprise through racketeering activities." *Id.*

[7] *Id.* (Barlow Deposition, p. 86) ("Within the provisions as we found them it was clear to me it could be done under a fraud reference which was referenced in the racketeering statutes.")

[8] *Id.* (Barlow Deposition, pp. 89, 90) ("Q. Was it your feeling, your opinion that Mr. Gates [the State Insurance Commissioner] was pressuring you with that consent order to stop your investigation? A. He was ordering me to stop.

various amici that a $50,000 fine assessed to a fraud that produced increased profits of $33,741,103 demonstrates either adequate or effective state regulation.[9]

30,597 Co-Payors during the class period were

I contacted Mr. Kennedy [Humana counsel] and asked him what in the hell was going on. He confirmed Mr. Gates' information that the consent order was there; that they [the Humana entities] were not going to sign it until such time as the criminal investigation was stopped for fear of that being used against them in a prosecution.")

[9] *See* Amici Curiae Brief of Alliance of American Insurers, et al., at 18-22. The fact that the Nevada Attorney General prepared a state RICO criminal complaint to address the exact same billing fraud underlying this federal RICO civil complaint guts the Alliance's claim that "Nevada has specifically chosen to punish insurer fraud in a different manner than RICO mandates . . . ." *Id.* at 21. Similarly, *In re: Prudential Ins. Co. of Amer. Sales Practice Litig. Agent Actions*, 1998 U.S. App. LEXIS 17057 (3rd Cir. 1998), actually illustrates that private litigation is the primary watchdog that wakes up state regulators. The *Prudential* court observed that Prudential's illegal activities first came to light through private lawsuits filed in early 1994, which triggered a front-page news article. *See* Leslie Scism, *Fine Print Victims: Some Agents 'Churn' Life Insurance Policies, Hurt Their Customers*, WALL ST. J., Jan. 3, 1995, at 1. In April 1995, more than a year after the first private suit, the Multi-State Life Insurance Task Force was reported. *Prudential* and the present case prove that private claims for relief are absolutely crucial to ensure that victims of insurance fraud receive restitution.

patients at Humana Hospital. They paid Humana over $5,000,000.[10] These Co-Payors seek RICO damages for the difference in their actual co-payments and co-payments calculated upon discounted hospital charges.

After the fact refunds of recalculated co-payments based on the 89% discount provide no compensation for Co-Payors who declined or moderated medical treatment because of co-payment over-charges.[11] All 84,000 Co-Payors also seek RICO damages as compensation for the hospital usage discouraged or prevented by the excessive

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[10] The $5 Million figure includes $3 Million based on Humana's assertion that 3,003 (i.e., 16,412 minus 13,409) of the Co-Payors paid $1,000 but had hospital bills so high that the $1,000 deductible was exceeded even if the discount was applied. CR 937. Another $2 million comes from Humana's initial claim that $2,009,378 million was due to the 13,409 other Co-payors. *Id.*

[11] Increasing the required co-payment by failing to provide the discount when Co-Payors were actually charged dramatically **decreased** utilization of medical benefits. *See Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698 (7th Cir. 1991) (recognizing that "Co-payments sensitize employees to the costs of health care, leading them not only to use less"); *Kansas Hosp. Ass'n v. Whiteman*, 835 F. Supp. 1556, 1566 (D. Kan. 1993), *aff'd, sub nom. Williams v. Whiteman*, 36 F.3d 1106 (10th Cir. 1994) (observing that "Congress generally approves and even encourages participating states to impose required [Medicare] co-payments . . . as a means of controlling utilization").

co-pay charge.[12]

B. Procedural History

Respondents accept the procedural history as presented by Petitioners.

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[12] The excessive hospital co-payment reduced hospital usage in two fundamental ways. First, by over-charging Co-Payors, Humana made the co-payment charges for specific services proportionately greater for each prospective co-payment. For example, if a hysterectomy costs $2,500, Humana's co-payment charge was 20% of $2,500 or $500. If the 89% discount is applied to the co-pay and retro-actively refunded, a hysterectomy would only have cost $275 with a $55 co-pay. By demanding $500 instead of $55 as the co-payment charge, Co-Payors were discouraged from using medical benefits. Second, the co-pay over-billing took away monies from the Co-Payors that were otherwise available for additional hospital treatment. In the hysterectomy example, if the $55 co-payment based on the discount had been charged instead of $250, the Co-Payor would have almost $200 left available for further medical treatment. **Even moderate over-charges to Co-payors greatly reduced benefit usage**. *Lacey v. Cohen*, 596 F. Supp. 1010, 1018 (E.D. Penn. 1984) (concluding that "imposition of recipient copayment decreases the overall utilization of medicaid services. . . . . **requiring individuals to meet even a nominal assessment for medically necessary goods and services forces those individuals to economize, and sometimes to forego treatment**"), *aff'd,* 774 F.2d 1152 (3rd Cir. 1985) (emphasis added).

SUMMARY OF ARGUMENT

The McCarran-Ferguson Act ("MFA") preempts the application of federal laws of general applicability to the business of insurance only when such federal laws "invalidate, impair, or supersede" state insurance law.[13] The interpretation and application of this phrase has created a rift between the circuits – one faction finding MFA preemption triggered only by a "direct conflict" between federal and state law, and the other deeming federal law preempted merely by potential upset to the balance of a state enforcement scheme (i.e. "inverse field preemption" given state law is preempting federal law).

As this Court recently summarized in *English v. General Electric Company*, 496 U.S. 72, 78-79 (1990), preemption may take one of three (3) forms: field preemption, express preemption, or direct conflict preemption. Respondents contend that the simple legal issue before the Court is whether direct conflict preemption or field preemption applies. Humana seeks to avoid proper preemption analysis by arguing that the MFA is not

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[13] Courts generally apply a four part test to determine whether the MFA operates to preclude the application of a federal law not expressly addressed by the MFA. If 1) the federal statute does not "specifically relate" to the business of insurance; 2) the challenged acts constitute the business of insurance; 3) the state has enacted laws to address the challenged acts; and 4) the application of the federal law would "invalidate, impair, or supersede" the state law, then the federal law may not be employed. *Department of the Treasury v. Fabe*, 508 U.S. 491, 515 (Kennedy, J., dissenting). Only the fourth prong is at issue in this case.

appropriately viewed under a preemption microscope and broadly asserting that the MFA per force precludes the application of RICO – or any federal remedy – to the business of insurance. Although Humana purports to disclaim applicability of field preemption analysis to MFA interpretation, when distilled, Humana's argument constitutes field preemption, contending that Congress, by enacting the MFA, intended to cede the field of insurance regulation to the states to the complete exclusion of all federal remedies.[14]

The RICO claims asserted herein by Respondents are not preempted by the MFA because they do not conflict with Nevada's state laws. RICO's policies, requirements

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[14] Though Humana cloaks its argument in an anti-preemption disguise, its basis in field preemption is manifest. The crux of Humana's position is that the MFA precludes the application of **any** federal statute with an independent remedy where a state insurance regulatory system has been enacted. *See* Petitioner's Brief on the Merits at 20-27. An interpretation this broad would necessarily preclude the application of all federal regulations -- civil **and** criminal. Accordingly, Humana is effectively interpreting the "invalidate, impair, or supersede" clause out of the MFA and advocating inverse field preemption of any federal law applicable to the business of insurance, if there is **any** state insurance regulation (unless Congress has expressed an explicit intent to the contrary). This clearly constitutes field preemption. Humana basically admits as much when it states: "if a federal preemption analysis were to be adopted . . . 'field' preemption . . . would appear to be the better analogy. . ." *Id.* at 14.

and remedies are consistent with, and merely supplement -- not supplant -- those embodied by Nevada's state regulatory scheme. This Court's jurisprudence clearly teaches that such consistent co-application of state and federal laws is not only permissible, but preferred. Moreover, in light of the contemporary pervasiveness of insurance fraud and the need for comprehensive remedies therefor, coupled with the reality that MFA preemption of RICO herein would also preclude application of RICO's criminal penalties to insurance fraud, public policy implores this Court to endorse the direct conflict test and affirm the Ninth Circuit's holding.

The Ninth Circuit decision should be affirmed for two distinct reasons: First, the fact that the direct conflict test applies and RICO does not "invalidate, impair, or supersede" Nevada's insurance laws is manifest by the express language and structure of the MFA, traditional rules of statutory interpretation, the legislative intent behind RICO and the MFA, this Court's precedent, and strong public policy concerns. Second, given that the Nevada Attorney General applied Nevada state criminal RICO to the exact same fraudulent conduct by Humana, the federal RICO claim asserted herein could never "invalidate, impair, or supersede" Nevada law in this specific case under either the "direct conflict" or "field preemption" analysis. *See Chevron USA, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-45 (1984) ("considerable weight should be accorded to an executive department's construction of a statutory scheme").

ARGUMENT

A. The McCarran-Ferguson Act Preempts the Application of Federal Laws Only to the Extent that they Directly Conflict with State Regulatory Schemes

1. The Express Language of the McCarran-Ferguson Act Demonstrates That Congress Did Not Intend to Cede the Entire Field of Insurance Regulation to the States.

"The starting point in a case involving construction of the McCarran-Ferguson Act, like the starting point in any case involving the meaning of a statute, is the language of the statute itself." *Department of the Treasury v. Fabe*, 508 U.S. 491, 500 (quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210 (1979)). Section 2(b) of the MFA, particularly the interpretation and application of the phrase "invalidate, impair, or supersede" is paramount in the instant case. Section 2(b) provided a rule for the construction of future acts of Congress: they shall not be construed to "invalidate, impair, or supersede" any law enacted by any state to regulate the business of insurance or impose a tax on it unless the act of Congress specifically relates to insurance. Under this interpretive rule, state law must give way to federal law, regardless of conflicts, when Congress expressly so provides.

When Congress does not expressly so provide, the MFA precludes the application of federal laws to the business of insurance only when they "invalidate, impair, or supersede" state insurance statutes. By this prong, Congress expressly limited MFA preemption to these particular instances, evidencing a clear intent not to vest in

the states exclusive control and regulation of the insurance business. "Had Congress intended to cede the field, it could have [simply] said: 'No federal statute shall be construed to apply to the business of insurance.'" *Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486, 1492 (9th Cir. 1995). However, by selecting and including these particular terms, Congress manifested a clear desire for the continued validity and applicability of federal laws to the insurance industry unless they effect an invalidation, impairment or supersession of a state insurance law, and Congress thereby implicitly recognized the lack of wholesale preclusion of federal laws in the field of insurance.

Petitioners argue that the term "impair" predominates and perverts the meaning of the entire phrase as to "lessen[] the force or significance of." Petitioners' Brief at 21. This approach thrice errs. First, it eliminates the "invalidate" or "supersede" terminology. Second, it flies in the face of *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 108 (1983), in which this Court construed the meaning of the term "impair" in the context of ERISA preemption of state laws relating to employee benefits[15] and concluded

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[15] The Court's focus was the definition of "impair," however, it is noteworthy that the entire preemption clause at issue in *Shaw* included the identical phrase "invalidate, impair, or supersede." *Shaw*, 463 U.S. at 101. The words "invalidate," "impair" and "supersede" express the same concept as "interpose" or "contravene" when used in general preemption cases. *See, e.g., Southern Pac. Co. v. Jensen*, 244 U.S. 205, 216 (1917) ("interpose" and "contravene"); *cf. Chevron U.S.A., Inc. v. Hammond*, 726 F.2d 483, 488 (9th Cir. 1984), *cert. denied*, 471 U.S. 1140

that "impair[ment]" or preemption occurred "only insofar as [the state law] prohibit[ed] practices that [we]re lawful under federal law" – or where the two directly conflicted. Thus, under this Court's established jurisprudence, "impair" should be ascribed a far more limited definition than suggested by Petitioners. *See also United States v. Southeastern Underwriters Ass'n.*, 322 U.S. 533, 587 (Jackson, J., dissenting) (citing *Terminal R.R. Ass'n v. Brotherhood of R.R. Trainmen*, 318 U.S. 1, 7 (1943) and stating "when power is exercised by Congress, it **impairs** state regulation **only** insofar as it **actually conflicts** with Federal regulation") (emphasis added). Third, as the legislative history of the MFA proves, the terms "invalidate, impair or supersede" were used interchangeably.[16] Unlike Petitioners, the drafters did **not** attach independent (or incompatible) meanings to each word. Hence, the literal language of the MFA supports the "direct conflict" test instead of "field preemption."

(1985) ("superseded").

[16] Implicitly rejecting the argument that the word "impair" could be relied upon to bootstrap a "field preemption" test into the MFA, the senators did **not** ascribe independent meaning to each word in the key phrase; instead, they interchangeably used one or more words as shorthand for the series. *See* 91 CONG. REC. at 485 (1945) (Senator Taft: "invalid"), 486 (Senator Revercomb: "invalidate"), 486 (Senator Murdock: "impair or invalidate"), 487 (Senator Radcliffe: "invalidate").

2. The Structure of the McCarran-Ferguson Act Also Indicates That Congress Did Not Intend to Preempt All Federal Regulation of the Insurance Industry.

The basic structure of the MFA disproves any Congressional intent to effect a field preemption of all federal regulation of the insurance industry. *See United States v. Turkette*, 452 U.S. 570, 583, 593 (1981) (stating that the Court can rely on statutory structure to determine legislative meaning). This Court has repeatedly acknowledged that "statutory interpretations that 'render superfluous other provisions in the same enactment' are strongly disfavored." *National Endowment for the Arts v. Finley*, __ U.S. __, 118 S. Ct. 2168, 2189 (1998) (Souter, J., dissenting) (quoting *Freytag v. Commissioner*, 501 U.S. 868, 877 (1991)). To read the "invalidate, impair, or supersede" clause of Section 2(b), as Petitioners suggest, to preclude the application of **all** federal laws when the other three prongs have been satisfied renders the anti-trust clause redundant or superfluous in violation of these elementary tenets of statutory construction. If all federal laws are preempted by the statute, the federal anti-trust laws are also precluded. Accordingly, in order for the MFA anti-trust clause to have full force and effect, Section 2(b) must be read so as to not preempt the application of all federal remedies to the insurance business.

Similarly, the MFA's statement that none of its provisions "shall be construed to affect in any manner the application" of the National Labor Relations Act, the Fair Labor Standards Act of 1938 and the Merchant Marine Act to the business of insurance, *see* 15 U.S.C.A. § 1014, is additional evidence that Congress did not effect field preemption of all federal laws to the business of insurance.

This express exception necessarily implies that, in enacting the MFA, Congress merely intended to affirm the states' continued ability to regulate the insurance industry, not to surrender the entire field of insurance regulation to the states.

3. This Court's Adoption of the Direct Conflict Test for Impairment, Invalidation and Supersession.

The proper application of the fourth prong of the MFA was first addressed by this Court in *Securities Exchange Commission v. National Securities, Inc.*, 393 U.S. 453 (1969), which determined whether the MFA preempted the application of federal securities laws to a proposed merger between two insurance companies previously sanctioned by the Arizona State Director of Insurance. Finding all other prongs of the MFA satisfied, Justice Marshall, writing for the Court, framed the central question as "whether the MFA bars a federal remedy which affects a matter subject to state insurance regulation." *National Securities,* 393 U.S. at 462. This Court expressly rejected the argument that "**any** [federal] attempt to interfere" with state regulated insurance activities would "invalidate, impair or supersede" the state laws, deeming such application of the MFA an "overly broad restriction on federal power." *Id.* at 463 (emphasis added).

This Court juxtaposed the federal and state remedies in question and focused on their ability to co-exist without conflict because the "paramount federal [and state] interest[s]" were "perfectly compatible and Arizona ha[d] not commanded something which the Federal Government [sought] to prohibit." *Id.* "In these circumstances," penned Justice Marshall, "we simply cannot see the **conflict**." *Id.*

National Securities endorsed the "direct conflict" test for "invalidat[ion], impair[ment] or superse[ssion]" that was properly employed by the Ninth Circuit in the instant case.

This Court revisited the application of the MFA's fourth prong in *Department of the Treasury v. Fabe.* Though primarily deciding whether the state law was enacted "for the purpose of regulating the business of insurance," *Fabe* observed that the fourth prong was satisfied because "there is a **direct conflict** between the federal" and state laws. *Id.* Additionally, in explaining the intended application of the MFA, this Court stated:

> Ordinarily, a federal law supersedes any inconsistent state law. The first clause of § 2(b) reverses this by imposing what is, in effect, a clear-statement rule, a rule that state laws enacted "for the purpose of regulating the business of insurance" do not yield to **conflicting** federal statutes unless a federal statute specifically requires otherwise.

Fabe, 508 U.S. at 507 (emphasis added).[17] This language

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[17] *Fabe's* four-Justice dissent strongly implied that "invalidate, impair, or supersede" means "conflict":

> The first clause of § 1012(b) is directed to the States and provides that state laws enacted for the purpose of regulating the business of insurance are saved from pre-emption if there is no **conflicting** federal law which relates to the business of insurance.

further affirms this Court's adherence to the "direct conflict" test to determine whether a federal law "invalidate[s], impair[s] or supersede[s]" state insurance law.

National Securities and *Fabe* eliminate any valid contention that the MFA effects a "field preemption." Because this Court has never considered whether the MFA precludes the application of RICO to insurance fraud merely because of the existence of some state insurance regulatory scheme, it should clarify that the "direct conflict" test is also applicable in RICO cases. The MFA does not preclude civil remedies under federal RICO in this case because there is no "direct conflict." This is further evidenced by Nevada's private insurance cause of action and state RICO penalties applicable to the targeted insurance fraud.

4. *McCarran-Ferguson Act Preclusion of Federal Laws Is Properly Analyzed Under a Traditional Preemption Framework.*

Instead of the uncharted quagmire to which Humana leads the Court, the MFA's preclusive effect on federal laws should be analyzed under a traditional preemption framework. As stated *supra*, the MFA springs from Congress' post-*Southeastern Underwriters* reaction to state fear that, absent legislation, state insurance laws would be trumped by federal laws under general Supremacy Clause jurisprudence. As this Court recognized in *National Securities* and *Fabe*, Congress' intent in cases of conflict

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Fabe, 508 U.S. at 515 (Kennedy, J., dissenting) (emphasis added).

was to reverse the preemption process and make state insurance laws supreme to federal laws of general applicability in prescribed circumstances. *National Securities*, 393 U.S. at 458-59; *Fabe*, 508 U.S. at 507. Thus, logic dictates that this legislative rule reversal does not relieve the MFA of its preemptive character and origin but instead requires that the MFA be viewed under a preemption lens focused by this Court's Supremacy Clause jurisprudence.[18]

As demonstrated *supra*, the MFA does not effect an inverse field preemption because the express language of the statute leaves room for the application of federal laws to the insurance industry. Along that same line, the "invalidates, impairs, or supersedes" language of the MFA does not explicitly pre-empt federal RICO and thus, no express preemption has occurred. This necessarily leaves only a conflict preemption analysis whereby federal RICO will be preempted by the MFA only "to the extent that it actually conflicts with federal law." *English*, 496 U.S. at 79; *see also Fabe*, 508 U.S. at 502.

This Court's statements in *National Securities* stand as testament to the propriety of the inverse preemption approach to MFA fourth prong analysis. Standard conflict preemption exists "where it is impossible for a private party to comply with both state and federal requirements."

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[18] The MFA "is a form of inverse preemption, so principles defining when state remedies conflict with (and so are pre-empted by) federal law are pertinent in deciding when federal rules 'invalidate, impair, or supersede" state rules." *NAACP v. American Family Mut. Ins. Co.*, 978 F.2d at 287, 296.

English, 496 U.S. at 79 (citing *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963)). This Court's fourth prong ruling in *National Securities* resulted from the understanding that "Arizona ha[d] not commanded something which the Federal Government s[ought] to prohibit," and thus, it was not impossible for a private party to simultaneously comply with the state and federal demands. *National Securities*, 393 U.S. at 463. *Fabe* expressly teaches that "federal law must yield only to the extent" that it conflits with state law. 508 U.S. at 502 (emphasis added). This nomenclature necessarily reveals this Court's recognition of the MFA as inverse conflict preemption, precluding the application of federal remedies to the business of insurance only when concurrent compliance with both state and federal requirements is physically impossible.

5. Treatment of McCarran-Ferguson Act Preemption of RICO by the Courts of Appeals.

While *National Securities* and *Fabe* are of primary import, it is telling that most Courts of Appeals have applied a "direct conflict" test. In cases involving federal statutes other than RICO, the First and Seventh Circuits have adopted the direct conflict approach to MFA fourth prong analysis to find no MFA preemption when the federal law and state administrative scheme merely overlap.[19]

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[19] *See Villafane-Neriz v. Federal Deposit Ins. Corp.*, 75 F.3d 727, 736 (1st Cir. 1996) (holding that lack of direct conflict between FDIC and Puerto Rico Insurance laws precluded application of MFA); *American Family*, 978 F.2d at 297 (reasoning that "[d]uplication is not conflict," and

Regarding RICO, The Third, Sixth, Eighth and Ninth Circuits have all addressed the effect of the MFA on attempts under federal RICO to combat insurance fraud in conjunction with a state administrative scheme. Relying upon *National Securities*, the Third and Ninth Circuits interpreted the fourth prong of the MFA to preclude the application of federal laws only when they directly conflict with or cannot co-exist with the state law. *See Sabo v. Metropolitan Life Ins. Co.*, 137 F.2d 185, 193 (3rd Cir. 1998); *Merchants*, 50 F.2d at 1491-92. Because the intent and application of RICO and the state schemes at issue in these cases were consistent with one another, these courts concluded that the MFA did not "invalidate, impair or supersede" state law and permitted the simultaneous application of RICO and state laws to fraudulent insurance practices. *See Sabo*, 137 F.2d at 194; *Merchants*, 50 F.3d at 1492.

The Eighth Circuit and, arguably, the Sixth Circuit,[20] have generated an improperly expansive application of the MFA, theorizing that RICO is preempted

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concluding that the MFA does not preclude application of the Federal Truth in Lending Act to insurance activity).

[20] Petitioner erroneously contends that the Fourth Circuit rejects the "direct conflict" test based on the summary affirmation of *Ambrose v. Blue Cross & Blue Shield of Va., Inc.*, 891 F. Supp. 1153 (E.D. Va. 1995), *aff'd* 95 F.3d 41 (1996), an unpublished decision lacking any precedential value. The Fourth Circuit's only published interpretation of the "invalidate, impair, or supersede" clause is *Mackey v. Nationwide Ins. Cos.*, 724 F.2d 419, 421 & n.2 (4th Cir. 1984), using language which embraces a "direct conflict" approach to MFA preemption.

without "direct conflict" because application of RICO's substantial remedial provisions to the insurance business somehow upsets the balance of the state administrative system by luring policy holders away from the state insurance commissioner's office and into federal court.[21] In reaching this conclusion, these courts erroneously ignored this Court's articulation and reaffirmation of the direct conflict test to adjudge whether RICO – or any other federal law of general applicability – is preempted under the MFA. *See Doe*, 107 F.3d at 1307 (quoting the "conflict" language of *National Securities* but finding "impairment" of Minnesota's delicately balanced regulatory scheme by

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[21] *See Doe v. Norwest Bank Minn., N.A.*, 107 F.3d 1297, 1306 (8th Cir. 1996); *Kenty v. Bank One, Columbus, N.A.*, 92 F.2d 384, 392 (6th Cir. 1996). Although the *Kenty* Court arrived at the same ultimate holding, the Court's analysis suggests that the MFA was triggered due to a "direct conflict" between RICO and the Ohio state law. *See Kenty*, 92 F.3d at 392 (noting that, under the Ohio scheme, "applying RICO to insurance companies would subject them to a different standard of behavior than the one envisioned by Ohio"). Thus, *Kenty* is more consistent with the direct conflict approach than "field preemption."

Kenty is also wrongly decided from another perspective. The Sixth Circuit panel failed to recognize the existence of Ohio's RICO statute, which authorizes treble damages for insurance fraud based on a federal standard of fraud. *See* OHIO REV. STAT. §§2923.31(I), 2923.34(B); *State v. Schlosser*, 681 N.E. 2d 911, 913 Ohio (1997) ("based on federal RICO statute").

RICO's "extraordinary," yet non-conflicting remedies).[22]

6. The "Direct Conflict" Approach is Consistent with Legislative History and the Intent of Both the McCarran-Ferguson Act and RICO.

Application of the "direct conflict" approach to conclude that the MFA does not automatically preempt the application of RICO to insurance fraud is also consistent with the legislative history of the MFA and the clear Congressional intent that the MFA be narrowly construed while RICO is given broad application.

a. The legislative history of the McCarran-Ferguson Act

The MFA is best understood in the context of the history of the insurance industry itself. Various segments of the insurance industry have historically been rife with fraud. *See generally*, 21 BRITANNICA, *Insurance*, 741-54 (15th ed. 1995). "As early as 1866, the insurance trade, though still in its infancy was subject to widespread abuse." *Southeastern Underwriters*, 322 U.S. at 544. Many of the early property insurance companies failed from speculative investments, poor management, and an inadequate distribution system. Little effective regulation existed and rate making was problematic and lacking sound basis.

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[22] *See also Ambrose*, 891 F. Supp. at 1164-68 (providing an extensive discussion of fourth prong application to RICO without a single reference to *National Securities* or *Fabe*).

The life insurance industry faced similar problems. After the Civil War, unearned dividends were improperly declared, reserves were inadequate and advertising claims were exaggerated. Between 1870 and 1872, thirty-three life insurance companies failed. Forty-eight more fell from 1873 through 1877. The call for the curtailment of these abuses resounded.

Given the industry's current purported penchant for state regulation, it is ironic that insurers initially cited federal power over commerce to fight state regulation; state legislative efforts were generally upheld by this Court. *Id.* at 584 (Jackson, J., dissenting) (citing *Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868)). Compounding the ironies, the industry actually requested federal regulation as a tactic to avoid more onerous state regulation. *See, e.g., id.* at 594 n.17 (Jackson, J., dissenting) (quoting Louis D. Brandeis).

This Court's decision in *Southeastern Underwriters* marked a turning point in the history of the regulation of the business of insurance, conclusively establiishing that it was interstate commerce and making the Sherman Act's provisions against restraint of trade fully applicable to insurers. Insurers feared that the end of the world was upon them. *See Note*, 23 CHI.-KENT L. REV. 317, 320 (1945) (collecting insurance industry comments and tracing the legislative history of the MFA).

During the 91st congressional session, unanimous agreement was quickly reached that state regulation and, most importantly, state taxation of the insurance industry had to be safeguarded. *See, e.g.*, 91 CONG. REC. 1092 (1945) (statement of Rep. Springer: "The states do not know what to do with respect to the collection of taxes and the insurance companies do not know what to do with

respect to the payment of taxes"). That taxation was the driving force for preservation of state regulation renders hollow Petitioner's grandiose claim that the MFA was really motivated by some sort of desire to allow states to continue regulating unsavory insurer conduct or provide policy holders with adequate "remedies afforded for violation of the norms set by the states." Petitioners' Brief at 26. In fact, the complete absence of such statements of legislative intent strongly suggests that no "field preemption," which would be triggered merely by state taxation, was contemplated for any future federal legislation redressing insurer misconduct.

The resulting enactment of the MFA was a compromise[23] fashioned by a conference committee that mediated between two broad factions in Congress: one, principally in the House, sought industry exemption from federal regulation, especially antitrust statutes; the other, principally in the Senate, sought substantial oversight of the industry by the federal government, especially through the antitrust statutes.

Support for application of the "direct conflict" test in this case is found in the legislative history of the genesis of the phrase: "invalidate, impair or supersede." Participants in the Senate debate defined the broad issue as one of potential "conflicts" between state and federal law. Influential Senators rejected application of the Act as "field preemptive," particularly with respect to the Sherman Act and the Clayton Act. *See* CONG. REC. 1478-81 (1945)

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[23] For a discussion of the development of the compromise, see 91 CONG. REC. 1484 (statements of Senator Murdock).

(statements of Senators Pepper and Murdock).[24]

For some Senators, exemption was out of the question. Senator Ferguson, for example, frankly acknowledged that his bill (S.340), as then drafted, was **not** designed simply to return the law to its pre-*Southeastern Underwriters* status. 91 CONG. REC. 478 (1945). Consistent with Ferguson's view, in the Senate debates, **the "invalidate, impair, or supersede" clause -- the crucial language now at issue – was described as a "catchall" provision specifically designed to encompass other acts of Congress that the drafters could not foresee at the time of the bill's drafting:**

> It is no secret that Senate bill 12, introduced by the Senator from New Mexico [Mr. Hatch] and myself, and Senate bill 340, the bill which was reported by the committee, are modifications of a measure which was

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[24] For other "conflict" references, see 91 CONG. REC. 479 (1945) (Senator Ferguson), 482 (President Roosevelt), 484 (Senator Taft) 486 (Senator Revercomb) and 487 (Senator Ellender).

The state insurance commissioner's proposed bill, which was the immediate source of "invalidate, impair, or supersede" in the MFA, was expressly "designed to eliminate or at best minimize **conflict** between State laws and existing or future acts of Congress...." PROCEEDINGS OF THE SEVENTY-SIXTH ANNUAL SESSION OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, 35 (Dec. 4, 1944) (emphasis added). Clearly, the MFA was not designed to enact "field preemption."

originally drafted by the legislative committee of the National Association of Insurance Commissioners. So there was an effort to work with those groups. In drafting those two bills we sought to spell out each particular law which might apply to insurance. We referred specifically to the Federal Trade Commission Act, the Robinson-Patman Act, the National Labor Relations Act, and the Fair Labor Standards Act. In other words, a good-faith attempt was made to specify every single law which had an application, or might have an application, to insurance.

> **Section 2 (b) was drafted and written into the bill which I introduced, in the belief, not that it would be interpreted as an additional exemption from the anti-trust laws, but that it would be a sort of catch all provision to take into consideration other acts of Congress which might affect the insurance industry, but of which we did not have knowledge at the time. . . .**

91 CONG. REC. 483 (1945) (statement of Senator O'Mahoney) (emphasis added). This drafter's statement that Section 2(b) was a "catch all" applicable to other federal laws rebuts any claim of field preemption.

The House representatives did not view the issue solely or principally as one of "conflict." Because the focus of the House was an exemption, comments of its members typically did not address and shed no light on the

"invalidate, impair or supersede" clause. *See, e.g.*, 91 CONG. REC. 1090 (1945) (Rep. Gwynne: "we are as far as possible removing ourselves from the field").[25]

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[25] Petitioners misplace reliance upon this one errant phrase by Rep. Gwynne. *See* Petitioners' Brief at 14. While it was surely Gwynne's desire to get an exemption, it was not the objective of the Senate or the ultimate compromise adopted by Congress. The procedural history of the MFA further reveals the limited significance of the House's initial exemption position, exemplified by Gwynne's comment. At the behest of the insurance industry, the House actually passed legislation in anticipation of the *Southeastern Underwriters* decision to exempt insurance from federal regulation. *See* H.R. 3270, 78th Cong., 1st Sess. (1943); 90 CONG. REC. 6565 (1944) (283 to 94). Vigorous and successful opposition by Senator O'Mahoney, a progressive and New Deal Reformer, killed the legislation in the Senate. *See* TIME, Dec. 13, 1943, at 82; NEW REPUBLIC, May 29, 1994, at 378. *See also Southeastern Underwriters* 322 U.S. at 591 n.12 (Jackson, J., dissenting) (quoting conclusions of Senator O'Mahoney on concentration of economic power and abuses of business). *Southeastern Underwriters* was then decided, and the new 91st Congress addressed the issue. Contrary to Rep. Gwynne's wishes, the revised legislation did not provide an exemption. As the critical O'Mahoney quote demonstrates, Congress did not remove itself from the field, it only limited its power, unless specifically stated in the MFA or the piece of legislation, to avoid superseding or impairing state legislation. The fact that Petitioners' argument is anchored squarely on the rejected House exemption position demonstrates its infirmity.

Compromise was ultimately reached in both bodies, *see* 91 CONG. REC. 1396 (1945) (House) ("substitute for both the Senate bill and the House amendment"); *id.* at 1489 (Senate), and the conference report was adopted by a vote of 68 to 8. *Id.* at 1489. No faction had obtained all that it desired in the MFA. Neither the insurance industry nor Rep. Gwynne obtained the coveted general exemption from federal law. On the other hand, assuming the states acted to regulate the industry, the antitrust statutes were not to be made fully applicable thereto, but the prohibition against boycotts, coercion and intimidation was left in place. Federal labor law was also expressly left in place. For other federal laws, if Congress spoke clearly, federal law remained controlling regardless of state action, even if directly conflicting. If Congress did not expressly speak, actual conflicts between state and federal law would be resolved by applying the "catch all provision" and determining if federal law did not "impair, invalidate or supersede" state law on a case by case basis–in short, the "direct conflict" test.

b. Congress intended for the McCarran-Ferguson Act to be narrowly interpreted and RICO to be broadly construed.

Since the inception of the RICO statutes, the Congress, this Court and the Courts of Appeal have consistently required that RICO, a remedial statute, be broadly interpreted.[26] *See* Pub. L. No. 91-452, § 904(a), 84

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[26] On numerous, recent occasions, this Court has flatly declined invitation to construe RICO narrowly in both

Stat. 947 (1970), stating that RICO must be "liberally construed to effectuate its remedial purposes").

In contrast, Congress intended -- and the courts repeatedly reinforce -- that the MFA must be narrowly construed, especially in areas of "national concern." *Cochran v. Paco,* 606 F.2d 460, 467 (5th Cir. 1979); *accord, State of Idaho ex rel Soward v. United States*, 858 F2d 445, 451 (9th Cir. 1988), *cert denied,* 490 U.S. 1065 (1989). Certainly, as the broad reach and comprehensive criminal and civil sanctions of the RICO statutes evidence, racketeering activity qualifies as a national concern warranting circumscribed application of the MFA. *See Turkette*, 452 U.S. at 588 (noting the national "pervasiveness" of America's racketeering problem as recognized in the preface to the Organized Crime Control Act of 1970).

National Securities and *Fabe* are illustrative of this

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criminal and civil appeals. *See, e.g., H.J., Inc. v. Northwestern Bell Tel. Co.*, 492 U.S. 229, 249 (1989) (noting that any restriction of RICO's broad scope "is a job for Congress"); *Tafflin v. Levitt*, 493 U.S. 455, 467 (1990); *United States v. Monsanto*, 491 U.S. 600, 609 (1989); *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 491 n.10, 497-98 (1985); *Russello v. United States*, 464 U.S. 16, 21 (1983); *Turkette*, 452 U.S. at 593. *See generally,* Blakey & Roddy, *Reflections on Reves v. Ernst & Young: Its Meaning and Impact on Substantive, Accessory, Aiding, Abetting, and Conspiracy Liability Under RICO*, 33 AM. CRIM. L. REV. 1345, 1350 n.7 (1996) (tracing the history of the liberal construction clause and collecting decisions, particularly in the criminal law area).

Court's recognition that Congress intended for the MFA to be narrowly construed. In *National Securities*, this Court expressly noted that the MFA "did not purport to make the states supreme in regulating all the activities of insurance companies," and refused to interpret the MFA as an "overly broad restriction on federal power." *National Securities*, 393 U.S. at 459. *Fabe* was also highly cognizant of the need for a circumscribed holding, commenting, in several passages, upon the "narrowness" of the *Fabe* conclusion.[27] *See Fabe*, 508 U.S. at 508, 509 n.8, 512. The broad construction of the MFA and narrow application of RICO advocated by Petitioners is hopelessly inconsistent with the clear Congressional intent behind these legislative efforts.

Additionally, RICO's express "no supersession" clause further evidences the post-MFA intent of Congress that RICO be employed in conjunction with all other remedies -- state or federal. Congress specifically provided that the RICO remedies would not be construed to "supersede any provision of Federal, State, or other law . . . affording civil remedies in addition to those provided for in this title."[28] *See Turkette*, 452 U.S. at 587 n.9 (quoting Pub.

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[27] Where a displacement of the other body of law is incomplete, the preemption standard is necessarily the "actual conflict" standard. *See, e.g., California Coastal Comm'n v. Granite Rock Co.*, 480 U.S. 572, 581 (1987); *California Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 281 (1987).

[28] RICO does not expressly mention insurance in its text. S. Rep. No. 91, 60, 91st Cong., 1st Sess. 76 (1969), however, includes "insurance" among those legitimate businesses infiltrated by criminal groups. RICO, too, includes mail fraud among its predicate offenses. *See* 18

L. No. 91-452, § 904(a), 84 Stat. 947 (1970)). Explaining the effect of this clause in the criminal context, this Court stated in *Turkette*:

> Thus, under RICO, the States remain free to exercise their police powers to the fullest constitutional extent in defining and prosecuting crimes within their respective jurisdictions. That some of those crimes may also constitute predicate acts of racketeering under RICO is no restriction on the separate administration of criminal justice by the States.

Id. In the correlative civil arena, this clause operates to mandate co-application of RICO and state laws and ensures that the state laws will not be affected, restricted or supplanted by such co-application. *See id.; Haroco, Inc. v. American Nat'l Bank & Trust Co. of Chicago*, 747 F.2d 384, 392 (7th Cir. 1984), *aff'd* 473 U.S. 606 (1985). Thus, it is clear that Congress harbored the express, post-MFA intention that RICO remedies and state insurance regulations operate and exist side by side. Any interpretation of the MFA as limiting this co-application is

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U.S.C. §1961(b). In 1970, it was well-settled that the MFA did **not** preclude criminal prosecutions under mail fraud. *See, e.g., United States v. Sylvanus*, 192 F.2d 96, 100 (7th Cir. 1951), *cert. denied*, 242 U.S. 943 (1952). That Congress should have done more to indicate its intent that RICO apply in the area of insurance fraud is, therefore, doubtful. *Cannon v. University of Chicago*, 141 U.S. 677, 696-97 (1979) (stating that it is "always appropriate to assume that our elected representatives...know...the law").

therefore squarely inconsistent with RICO's express text and violates the mandate of Congress.

B. Federal Rico Does Not Conflict with Nevada's Insurance Or Racketeering Laws

A direct conflict exists between state and federal law where "it is impossible for a private party to comply with both state and federal requirements," *see English*, 496 U.S. at 79 (citing *Florida Lime & Avocado Growers, Inc.*, 373 U.S. at 142-43), or where one law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of" the legislative body adopting the other. *Id.*, (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)). RICO does not conflict with Nevada's insurance regulatory system because an insurer can -- and should -- simultaneously comply with federal RICO and with the Nevada insurance regulations, as well as all other aspects of Nevada law, including Nevada's racketeering statutes. The application of federal RICO's civil remedial provisions erects no barrier to the full enforcement of Nevada's regulatory remedies by the State Insurance Commissioner, or by Nevada's Attorney General. This lack of direct conflict is evident under the precedent of this Court because of the harmonious policies of the state and federal system, the peaceful coexistence of their cumulative remedies, and the presence of multiple state remedies applicable and actually applied to the exact same fraudulent conduct.

1. The Policies Behind the Federal and State Laws Are Compatible.

The federal policies embraced by RICO and the legislative purpose behind either the Nevada Trade

Practices and Frauds; Financing of Premiums Act or, alternatively, the Nevada racketeering statutes, are in no way incompatible. Federal RICO was adopted to provide liberal remedies to those victimized by patterns of criminal behavior. *Sedima,* 473 U.S. at 487. Obviously, the Nevada racketeering statute was adopted to address the exact same concerns. *See Hale v. Burkhardt*, 764 P.2d 866, 867 (Nev. 1988) (noting that Nevada state RICO is "patterned after" federal RICO). Not inconsistently, the asserted purpose of the Nevada insurance regulatory scheme "is to regulate the trade practices in the business of insurance . . . which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting [such] trade practices. . . ." NEV. REV. STAT. § 686A.010. Although the federal RICO remedy does not exclusively affect matters addressed by the Nevada statutes, the remedies in both schemes seek to deter and redress unfair or deceptive trade practices.[29]

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[29] Following the District Court, 827 F. Supp. at 1522 n.33 ("exclusive jurisdiction" implies limited recovery for insurance fraud), Petitioners contend that Nevada's RICO statute does not encompass insurance fraud. *See* Petitioners' Brief at 7 n.4 & at 23. At the outset, if Humana really believed this true, it would not have coerced a settlement of the State of Nevada RICO criminal complaint. *See supra* note 7. Regardless, Humana's analysis is erroneous. It posits that fraud by the insured (NEV. REV. STAT. §§ 686A.290-291), but not fraud by the insurer (NEV. REV. STAT. §§ 686A.020, 686A.030 and 686A.40) was incorporated into NEV. REV. STAT. §207.360 *et. seq.* In response, while the insurance commissioner's jurisdiction to regulate is "exclusive," that jurisdiction is fully consistent with offenses covering the "same" conduct

2. Different Remedies Do Not Give Rise to a Conflict.

The co-application of the variant remedies afforded by federal RICO and the Nevada regulatory scheme do not

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defined outside of the Nevada Insurance Code, NEV. REV. STAT. § 679A.180 (1), and with implied and express private claims for relief for insurance fraud by the insurer but not the insured. *See Crystal Bay Gen. Improvement District v. Aetna Casualties & Sur. Co.,* 713 F. Supp. 1371, 1375-77 (D. Nev. 1989). An insured may also sue the insurer under common law theories for fraud. *See, e.g., Bankers Trust Co. v. Pacific Employers Inc., Co.,* 282 F.2d 106, 110 (9th Cir. 1960) (applying Nevada law and permitting private tort suit against insurer for deceit), *cert. denied,* 368 U.S. 822 (1961). In addition to the express provisions for insurance fraud, the predicate offenses in NEV. REV. STAT. §207.360 also include obtaining money by false pretenses – conduct involved in this Petition. In fact, Deputy Attorney General Barlow relied upon this statutory authority in preparing the Nevada RICO criminal complaint against Humana for the unlawful over-billing. *See supra* note 7. The contention that NEV. REV. STAT. §207.350 *et. seq.* does not, therefore, apply to fraud by an insurer against an insured cannot be credibly maintained.

Moreover, NEV. REV. STAT. §686.291 (1) (b) itself applies to the conduct at issue in this Petition. By its terms, it is not limited to conduct by an insured, as are the other three subsections of the provision. *See Russello*, 464 U.S. at 22. As such, Subsection (1) (b) protects the integrity of the claims process from fraud by either the insurer or insured.

give rise to a conflict. This Court's decisions unequivocally recognize that additional and different yet non-conflicting remedies are not preemptive.

In *Silkwood v. Kerr-McGee*, 464 U.S. 238 (1984), this Court observed that the proper approach to preemption was to consider "whether there is an irreconcilable conflict between the federal and state standards or whether the imposition of a state standard in a damages action would frustrate the objectives of the federal law." *Id.* at 256. That approach in hand, this Court squarely upheld the concurrent imposition of federal fines and state punitive damages for the **same** tort, rejecting the related argument that the award of punitive damages for radiation hazards was barred because it conflicted with the federal remedial scheme, and finding no conflict between the federal and state laws. As this Court observed:

> Paying both federal fines and state-imposed punitive damages for the same incident would not appear to be physically impossible. Nor does exposure to punitive damages frustrate any purpose of the federal remedial scheme.

Silkwood, 464 U.S. at 257.

Subsequent opinions of this Court consistently follow the trail marked by *Silkwood*, and have found preemption inapplicable to the concurrent assessment of federal fines and state fraud damage awards for cigarette advertising disclosure violations, *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 546 (1992), anti-trust violations, *California v. ARC Am. Corp.*, 490 U.S. 93 (1989) (permitting levy of federal **treble damages**

simultaneously with state fraud damages), nuclear whistle-blower actions, *English*, 496 U.S. at 89-90 (rejecting concerns that prospective litigants will forego administrative remedies for broader tort recovery and approving concurrent application of administrative remedies under the Energy Reorganization Act of 1974 and compensatory and punitive damages for state tort claims), and medical safety breaches. *Hillsborough County v. Automated Medical Labs., Inc.*, 471 U.S. 707, (1985). Thus, this Court has established beyond question that where "state and federal rules [ ] are substantially identical but differ in penalty, [they] do not conflict with or displace each other," and may (and indeed, should) be applied simultaneously. *American Family*, 978 F.2d at 297.

Federal RICO permits an injured plaintiff to recover for the same illegal or fraudulent activities proscribed by the Nevada insurance administrative scheme and the Nevada racketeering statutes. Both systems punish insurers engaging in fraudulent insurance practices though, as Petitioners note, RICO necessarily provides broader remedies than many state insurance schemes employ. *But see infra* note 35. This slight divergence between the remedial magnitudes of the state insurance system and federal RICO, however, is not dispositive, especially given the Nevada racketeering statutes.

As this Court recognized in *Silkwood*, tension between state and federal remedies must be tolerated. *Silkwood*, 464 U.S. at 256. This principle also pervades *California v. ARC America Corp.*, wherein this Court acknowledged that "ordinarily, state causes of action are not pre-empted solely because they impose liability over and above that authorized by federal law." 490 U.S. at 105. As RICO merely provides more flexible procedures or

greater remedies and compliance therewith does not force a violation of or overrule state law, there is no preemptive conflict between these remedies.

3. Supplementation Is Not Conflict.

This Court's decisions also reflect an understanding that supplementary remedies do not give rise to preemption but rather, further the remedial purposes behind the individual remedies. In *Cipollone v. Liggett Group, Inc.*, 505 U.S. at 516, this Court noted:

> In the absence of an express congressional command, state law is preempted if that law actually conflicts with federal law, or if federal law so thoroughly occupies a legislative field "as to make reasonable the inference that Congress left no room for the States to supplement it."

505 U.S. at 516 (quoting *Fidelity Fed. Sav. & Loan Ass'n v. De la Cuesta*, 458 U.S. 141, 153 (1982)). Reasoning that supplementation is not conflict sufficient to invoke the Supremacy Clause, this Court held that state common law claims against cigarette manufacturers were not preempted by federal laws regulating warning labels. *Id.*

This Court reiterated the propriety of the co-application of supplemental but not directly conflicting remedies in *Medtronic, Inc. v. Lohr,* 518 U.S. 1087, 116 S. Ct. 2240 (1996). In support of the *Medtronic* holding that the availability of federal remedies under the Food, Drug and Cosmetic Act does not preempt state tort remedies for the same conduct provided the requirements of state and federal law are consistent, this Court reasoned:

> The presence of a[n additional] damages remedy does not amount to [a] . . . different "requirement" rather, it merely provides another reason for manufacturers to comply with identical existing "requirements" under federal law.

Medtronic, 116 S. Ct. at 2255. Justice O'Connor's concurrence further elucidates the rationale behind and necessity for permissive co-application of federal and state remedies:

> **To be sure, the threat of a damages remedy will give [tortfeasors] an additional cause to comply,** but the requirements imposed on them under state and federal law do not differ. [Federal law] does not preclude states from imposing different or additional remedies, but only different or additional requirements.

Id. at 2264 (O'Connor, J., concurring in part and dissenting in part) (emphasis added).

The compatibility and allowance for joint implementation of federal RICO and the Nevada State insurance regulation scheme is also made apparent by the existence of Nevada's own state RICO statutes (which the Nevada Attorney General sought to apply to Humana's fraudulent conduct in this case). *See supra* note 7. Compatibility is further demonstrated by Nevada's common law remedies for insurance fraud, the availability of a private right of action under Nevada's insurance scheme and Nevada's allowance of treble punitive damages.

Like the federal RICO statutes, Nevada's racketeering scheme prescribes civil remedies (treble damages, attorneys fees and costs and civil forfeiture)[30] and criminal penalties (punitive fines[31] and criminal forfeiture) for engaging in a racketeering enterprise. *See* NEV. REV. STAT. §§ 207.350-520. As Nevada RICO parallels the remedies provided by federal RICO, any purported "impairment" of the state insurance regulatory system feared by Petitioners has already been effected by Nevada's own RICO statutes.[32] Humana's real complaint is that the

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[30] *See* NEV. REV. STAT. § 207.460-470.

[31] In addition to criminal forfeiture, Nevada's racketeering laws provide for imposition of a criminal fine not to exceed three times the greater of: 1) the racketeer's gain, or 2) his victim's actual loss. *See* NEV. REV. STAT. § 207.410.

[32] Similar considerations regarding Pennsylvania's general consumer protection statutes impacted the Third Circuit's holding in *Sabo* that RICO did not "invalidate, impair, or supersede" the state insurance regulation scheme. As the panel explained:

> [Pennsylvania's] general consumer protection statute, [which] provides a private remedy and treble damages for victims of insurance fraud . . . certainly undercuts any purported balance struck by the Pennsylvania legislature favoring administrative enforcement to the exclusion of private damages actions and we see no reason why a federal private right of action cannot coexist with the [Pennsylvania

sweetheart deal it cut with the Nevada Insurance Commissioner to eliminate the Nevada RICO **criminal** charges being pursued against it did not and could not eliminate civil RICO remedies. This highlights the reasons why implementation of federal RICO remedies to the same activities covered by the state racketeering laws would certainly not constitute impairment and will only bolster the remedial goals of the state RICO scheme.

In addition to the state RICO remedy, the treble damages available under federal RICO are identical to those offered by Nevada's common law fraud statutes. In addition to the Nevada RICO statute, the Nevada legislature has authorized a common law fraud plaintiff to recover treble punitive damages for fraudulent conduct in addition to compensatory or actual damages.[33] Hence, whereas federal RICO allows treble actual damages, Nevada general law authorizes **four** times actual damages (i.e., compensatory damages, plus treble punitive damages).

Further proof of the complete absence of "impairment" in this case of the Nevada state system by

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> scheme] in these circumstances.

Sabo, 137 F.3d at 195 (internal citations omitted).

[33] *See* NEV. REV. STAT. § 42.005 (permitting recovery of punitive damages for fraud but limiting such award to treble compensatory damages). Prior to the 1989 enactment of § 42.005, a Nevada fraud claimant's recovery of punitive damages was limited only by a reasonableness standard and was not required to bear any proportion to compensatory damages. *See Amoroso Constr. Co. v. Lazovich & Lazovich*, 810 P.2d 775, 778 n.1 (Nev. 1991).

federal RICO is the availability of a private right of action under the Nevada Unfair Insurance Practices Act itself. Although an **express** private cause of action has only been prescribed by the Act since 1987, an **implied** right has been available since the Act's inception. *Crystal Bay* 713 F. Supp. At 1377, *cited with approval in Hart v. Prudential Property & Casualty Ins. Co.*, 848 F. Supp. 900, 903 (D. Nev. 1994). The Nevada district court has reasoned that private remedies for insurance practices governed by the Nevada regulatory scheme are beneficial, desirable and "entirely consistent with the underlying purpose of the legislative scheme" because "the insurance commissioner does not have the staff and resources to investigate" the claim of each aggrieved insured. *Crystal Bay*, 713 F. Supp. at 1377.[34] Thus, the affirmation of the Ninth Circuit's holding in this case will not only be consistent with this Court's precedent and serve to effectuate Congress' intent in enacting the MFA, it will aid Nevada's statewide efforts to combat patterns of fraudulent insurance activity.

Given the availability of state racketeering and other

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[34] Petitioners attempt to avoid the fatal impact of the *Crystal Bay* case by contending that the absence of a Nevada Supreme Court opinion authorizing the pre-1987 implied private right of action somehow renders the federal courts' comprehensive analysis nugatory. *See* Petitioners' Brief at 7, n.4. Petitioners cite no authority in support of their argument that there is no pre-1987 private remedy for insurance practices. Moreover, two Nevada federal district courts have so held. *See Crystal Bay* and *Hart*. Further, one of those opinions, *Hart*, was penned by the very same federal judge (the Hon. Phillip Pro) who authored the MFA and RICO preemption opinion in this case.

civil remedies to insurance fraud, the co-application of federal RICO with Nevada's insurance regulatory system will not open the floodgates to litigation,[35] it will have a

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[35] Federal RICO actually only reaches a discrete subset of general insurance fraud, as it requires the presence of an "enterprise" and a "pattern of racketeering activity," elements "unknown to common law." *Agency Holding Corp. v. Malley-Duff & Assoc., Inc.*, 483 U.S. 150, 153 (1987) (noting the "sui generis nature of RICO"). Although the use of RICO to combat insurance fraud is already a well-established part of criminal and civil RICO litigation, *see, e.g., Russello,* 464 U.S. at 21 (1983); *United States v. Starnes*, 644 F.2d 673 (7th Cir. 1981), *cert. denied*, 454 U.S. 1981); *Schact v. Brown*, 711 F.2d 1343 (7th Cir.) *cert. denied*, 464 U.S. 1002 (1983); *North Carolina ex. Rel. Long. v. Alexander & Alexander Servs. Inc.*, 680 F. Supp. 746, 749-51 (E.D.N.C. 1988); Hon. James S. Long & Donald M. Wright, RICO Law, *Practice and Issues in the Context of Insurance Insolvency*, 9 JOURNAL OF INS. REG. 343, 374 (1991), RICO claims do not currently constitute a large or growing faction of civil litigation. From 1980-1996, the number of civil cases filed in federal courts increased from 168,800 to 272,700 per year. STATISTICAL ABSTRACT OF THE UNITED STATES 1997 at 216 (Table No. 346). The total number of civil RICO cases filled, however, **decreased** from 903 each year to 840 from 1993 to 1997. JUDICIAL BUSINESS OF THE UNITED STATE COURTS 1997 Table C-2A. Accordingly, this Court has no reason to fear that affirming this decision will inspire new RICO litigation that will crowd federal dockets.

This decline in RICO filings is best explained by this Court's much-awaited "pattern" decision in *H.J., Inc. v.*

negligible, if any, effect on the courts' dockets because federal civil RICO will merely be an additional (though significant) cause of action that replicates state claims.

As Justice Blackmun stated in *English v. General Electric Company*, "[t]he Court has observed repeatedly that pre-emption is ordinarily not to be implied absent an 'actual conflict.' The 'teaching of this Court's decisions enjoin[s] seeking out conflicts between state and federal regulation where none clearly exists.'" *English*, 496 U.S. at 90 (quoting *Huron Portland Cement Co. v. Detroit*, 362 U.S. 440, 446 (1960)) (internal citations omitted). Accordingly, because no direct and clear conflict exists between federal RICO and Nevada's private remedies for insurance practices or, alternatively, Nevada's applicable state racketeering statute, the only appropriate holding on the effect of the MFA on RICO's application to insurance fraud is that offered by the Ninth Circuit in *Merchants* and in the instant case.

C. Public Policy Compels the Availability of RICO Remedies to Insurance Fraud

The blight of health care fraud has recently crept to the forefront of public attention and law enforcement efforts. The United States Attorney General properly characterizes health care fraud as the second biggest criminal problem in the United States (next to terrorism). Thomas O'Donnel, *Clinton Enters Fray Over Health-Care Fraud*, DENV. BUS. J., July 18, 1997, at 15B. Insurance

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Northwestern Bell Tel. Co., 492 U.S. 229, 236-49 (1989), which narrowed the scope of RICO applicability. *See* Blakey & Roddy, *supra* note 26.

scams and kickbacks are identified as a major vehicle for criminal enterprises that pirated as much as 20% of national health care expenditures in 1994 alone. Jay Greene, *FBI Takes a Bite out of Healthcare Crime*, MOD. HEALTHCARE, Apr. 29, 1996, at 126. "Health care fraud, it appears, is evolving just as rapidly as the medical marketplace," Julie Johnson, *Managed Care Fraud: To Track Down Crime, Federal Officials Follow the Money Trail*, AM. MED. NEWS, May 20, 1996, at 3, and the present health care fraud crisis is marked by "obvious and deeply disturbing" parallels to the early stages of the savings and loan debacle. Blakey & Perry, *An Analysis of the Myths that Bolster Efforts to Rewrite RICO and the Various Proposals for Reform: "Mother of God -- Is This the End of RICO?,"* 43 VANDERBILT L. REV. 851, 892 n.115 (1990).

As this case demonstrates, Humana was an innovator of health care fraud with its illicit billing scheme. Key employees in Humana did not change their practices after being caught red-handed in this case. Humana simply merged with, and changed its name to, Columbia/HCA. Health care fraud by Columbia/HCA presently offers the highest profile in the unfortunate health care fraud line up. One reporter observed, "it is rare to pick up a daily newspaper anymore without seeing a news account about possible health-care fraud at Columbia/HCA Healthcare Corp. . . ." *Two Big For-Profit Hospital Chains Face Consumer Foes*, PITT. POST-GAZETTE, Aug. 5, 1997, at E1.

Although the state administrative remedies for insurance fraud and state RICO statutes are currently a helpful tool in the war against health care predators who prey on guileless patients, federal RICO is a powerful complementary private right of action against these

offenders.[36] The state and federal systems necessarily share a common goal of eradication of fraudulent insurance practices. Application of federal RICO remedies only furthers the laudable policies that the state and federal remedies share. *See Herman & McLean v. Huddleston*, 459 U.S. 375, 386 (1983) (application of cumulative remedies furthers their remedial purposes). Moreover, the presence of federal criminal and civil RICO penalties for health care fraud is particularly important because federal authorities and courts are typically not as malleable as the Nevada Insurance Commissioner was in this case.[37] For these reasons, while state and federal racketeering statutes may theoretically address the same unlawful conduct, the

[36] *See Agency Holding Corp.*, 483 U.S. at 151 (recognizing the necessity for "private attorneys general [for] a serious national problem for which public prosecutorial resources are deemed inadequate"); *Shearson/American Express, Inc. v. McMahon*, 402 U.S. 220, 241 (1987) (suggesting the need for "vigorous incentives for plaintiffs to pursue RICO claims); *Sedima*, 473 U.S. at 493 ("private attorney general provision . . . [is] designed to fill prosecutive gaps") (citing *Reiter v. Sonotone Corp.*, 442 U.S. 330, 344 (1979) (anti-trust)). RICO, like the anti-trust statutes, is well-integrated. "There are three possible kinds of force which a firm can resort to: violence (or the threat of it), deception or market power." CARL KAYSEN & DONALD TURNER, ANTI-TRUST POLICY: AN ECONOMIC AND LEGAL ANALYSIS 17 (1995). RICO focuses on the first two; anti-trust focuses on the third. Just as the anti-trust statutes seek to maintain economic freedom in the marketplace, RICO seeks to promote integrity in the market place – physical or fiscal.

[37] *See supra* notes 9-10 and accompanying text.

practical effect of a dual federal-state remedy is significantly greater deterrence.

The far reaching implications that MFA preemption of RICO would have should be a major concern. To hold that RICO application to insurance fraud is automatically preempted by the MFA merely because there is some state insurance regulation would preclude application of RICO's civil remedies **and criminal penalties** alike.[38] The text of

[38] Those courts of appeal and others that seek to draw a distinction between criminal prosecutions and civil litigation under RICO for the purpose of the MFA are, at best, disingenuous. *See, e.g., United States v. Blumeyer*, 114 F.3d 758, 768 (8th Cir.) (criminal mail fraud distinguished from civil RICO), *cert. denied*, 118 S. Ct. 350 (1997); Brief for United States As Amicus Curiae at 18 (same). As this Court has recognized, if an area of law is preempted civilly, it is, of course, preempted criminally. *See, e.g., United States v. Hutcheson*, 312 U.S. 219, 234-35 (1941) (labor) ("[Split preemption] is not the way to read the will of Congress."). *See also English*, 496 U.S. at 83 (rejecting the notion that preemption can apply in civil cases but not in criminal cases); *United States v.DeLaurentis*, 491 F.2d 208, 210-14 (2nd Cir. 1974) (labor preemption precludes Civil Rights Act criminal prosecution); *United States v. Bailey*, 120 F. Supp. 614, 632-33 (S.D. S.Va. 1954) (same). In fact, criminal prosecutions are generally preempted or not analyzed under precisely the same standards applicable to civil litigation. *See, e.g., United States v. Cavin*, 39 F.3d 1299, 1305 (5th Cir. 1994) (federal criminal prosecution not preempted under MFA unless "conflict"; "completely compatible" with the state's regulatory interest) (citing *National*

the MFA differentiates not between civil and criminal federal statutes. If the interpretation of the MFA's fourth prong urged by Petitioners is accepted, virtually **all** federal criminal laws potentially applicable to insurance fraud would be preempted because most (if not all) criminal penalties necessarily differ from the generally more lenient civil administrative remedies prescribed by state insurance regulations. Such application of the MFA would hobble law enforcement and proliferate health care fraud. Clearly, such a result was not intended by Congress when it enacted the MFA, nor is it in the best interests of our Nation.

Cardozo put it well: "Consequences cannot alter statutes, but may help fix their meaning. Statutes should be so construed, if possible, that absurdity and mischief be avoided." *In Matter of Rouss*, 116 N.E. 782, 785 (N.Y. 1917). This Court should heed these words and ought not create a safe harbor for crime under the MFA where its language, intent, and legislative history clearly does not compel one.

Securities, 393 U.S. at 453). On the relation between civil and criminal RICO, see *Sedima*, 473 U.S. at 489; *Shearson/American Express,* 482 U.S. at 239; *H.J. Inc.*, 492 U.S. at 236; *cf. United States Ex. Rel. Marcus et. Al. v. Hess*, 317 U.S. 537, 542 (1943) (False Claims Act); *Northern Sec. Co. v. United States*, 193 U.S. 197, 401 (1904) (Holmes, J. dissenting) ("The words cannot be read one way in a suit which is to end in fine and imprisonment and another way in one which seeks an injunction.").

CONCLUSION

For the foregoing reasons, this Court should affirm the Ninth Circuit's holding that the MFA does not preclude application of federal RICO to the fraudulent overbilling by Humana Insurance in this case.

September 18, 1998.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

HUMANA INC. AND
HUMANA HEALTH INSURANCE OF NEVADA, INC.,
Petitioners,

v.

MARY FORSYTH, MARIETTA CADE,
WILLIE ANDREWS, MARY LOU BUEHLER,
HELEN STAVES, RANDOLPH BRATTON,
AND SEARLE AUTO GLASS, INC.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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October 23, 1998

PARTIES TO THE PROCEEDING BELOW

Pursuant to Supreme Court Rule 29.6, Petitioners refer the Court to Page ii of their Brief on the Merits. There have been no changes since the filing of that brief.

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In The

SUPREME COURT OF THE UNITED STATES

October Term, 1998

No. 97-303

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v.

Mary Forsyth, Marietta Cade,
Willie Andrews, Mary Lou Buehler,
Helen Staves, Randolph Bratton,
and Searle Auto Glass, Inc.,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

REPLY BRIEF ON THE MERITS OF PETITIONERS

In their opening Brief on the Merits, petitioners observed that the logic underpinning the decision of the Ninth Circuit below, and the decisions of the other circuits that share its view, is flawed. In using an "inverse" federal preemption analysis to justify a "direct conflict" test for the application of the McCarran-Ferguson Act, the Ninth Circuit failed to appreciate that it was using principles developed to

protect the legislative decisions of the states from federal interference to circumscribe a statute intended to foster that same goal. Neither respondents nor the *amici* who have submitted briefs supporting them have attempted to refute this observation. Respondents and most *amici* defend the Ninth Circuit's use of a "direct conflict" test and look to the federal preemption cases for the formulation of that test.[1] None of them justifies that approach, however, by adopting the reasoning of the circuits below, and none attempts an explanation for the logical conundrum presented by the use of states' rights principles to restrict a states' rights statute. Like the fictional observation regarding the deficiencies in the emperor's wardrobe, there is no denying the truth of this observation once made.

As petitioners urged in their opening brief, the reach of the McCarran-Ferguson Act must be determined by reference to the ordinary rules of statutory interpretation. If the "direct conflict" test is to be adopted, it is there that it must find its support; but there is no support to be found. Neither the language of the McCarran-Ferguson Act, nor its structure, nor its history, nor any of the other matters to which respondents, the United States and the other *amici* point will justify the use of that restrictive test. A material variance between state and federal law that renders the state law superfluous -- as is demonstrably the case with RICO

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[1] The brief of *amicus* National Association of Insurance Commissioners ("NAIC")--which is stated to be in support of affirmance but not in support of respondents--does not support the "direct conflict" test but proposes a test that looks at conflicts arising "directly or indirectly." (NAIC Br., pp. 18-19.)

and Nevada law here -- "impairs" or "supersedes" that state law and triggers the prohibitions of the Act.

ARGUMENT

A. The "Direct Conflict" Test Misinterprets The McCarran-Ferguson Act.

As their lead argument, respondents and the government both attempt to defend the "direct conflict" test.[2] Before addressing that issue, however, it is important to note that the argument actually presented by respondents has less to do with justifying that restrictive test than it does with attacking the proposition that the McCarran-Ferguson Act should be applied using "field preemption" principles.[3] This argument attacks a strawman, for petitioners do not urge the application of those principles. *No* federal preemption analysis provides an appropriate way to apply the McCarran-Ferguson Act, and petitioners expressly so noted in their opening brief. (Brief on the Merits of Petitioners ("Pet. Br."), p. 14.)

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[2] Respondents preface this argument with a lengthy recitation of their view of the "facts" of petitioners' alleged misconduct, most of which remain to be tried and are hotly contested. Rehearsing that factual dispute is not of assistance to the interpretive question before the Court.

[3] The government makes a similar mischaracterization of petitioners' argument in its brief. (Brief of the Untied States as Amicus Curiae in Support of Respondents ("U.S. Br."), p. 25).

Federal law applies to the business of insurance unless the federal statute in question "invalidates, impairs or supersedes" state law, and the question before the Court is the meaning of that phrase. It is not petitioners' contention that this phrase precludes application of all federal law, only that it precludes federal law that is at material variance with state insurance law--as to substantive prohibitions, procedures or remedies. That preclusive effect appears in the language, structure and history of the Act.

1. The Language of the McCarran-Ferguson Act Does Not Support the "Direct Conflict" Test.

Respondents and the government both begin their arguments by acknowledging that the interpretation of the McCarran-Ferguson Act must begin with its language, and they purport to find support for the "direct conflict" test in that language. (Brief on the Merits for Respondents ("Resp. Br."), pp. 12-14; U.S. Br., pp. 10-21.)

For their part, respondents argue: (i) the McCarran-Ferguson Act does not provide that federal statutes shall not "apply" to the business of insurance, thus manifesting an intent not to cede the entire field to the states; (ii) the phrase "invalidate, impair or supersede" must be read as a whole without separately parsing the meanings of its three components; (iii) this Court has already equated "impair" with "direct conflict" in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 108 (1983); and (iv) in the floor debates on the Act, the senators and representatives used the three components of the critical phrase interchangeably without ascribing separate meaning to each. These arguments are without merit.

To begin, none of these arguments, other than the reference to the *Shaw* decision, even addresses the propriety of using the "direct conflict" test. The observation that Congress did not provide that no federal act shall "apply" to the business of insurance addresses the "field preemption" argument that petitioners are not making. Respondents' argument that the three components of the phrase "invalidate, impair or supersede" should not be separately interpreted and applied attacks petitioners' interpretation of the phrase but does not defend equating it with the "direct conflict" test. This argument is also contrary to the interpretive principle that, when words are used in the disjunctive, each must be given its separate meaning -- a principle that is not vitiated by respondents' related argument that the words were not used with precision in the floor debates. *See, e.g., Garcia v. United States*, 469 U.S. 70, 73 (1984).

Respondents' only argument actually addressed to the propriety of using the "direct conflict" test -- their citation to *Shaw v. Delta Air Lines* -- simply misreads the case. The Court's discussion of the meaning of "impair" in *Shaw* involved the application of § 514(d) of ERISA which provides that ERISA shall not "be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States," and that discussion is not supportive of respondents' position. 463 U.S. at 100-02. To the contrary, the Court there notes that an interpretation of ERISA that would leave the substantive provisions of Title VII of the Civil Rights Act unaffected but would preempt state laws that provide procedures and remedies that Congress intended be available to litigants in Title VII's enforcement *would* "impair" federal law. *Id.* at 102. That is hardly the "direct

conflict" test that respondents would apply and is, in fact, supportive of the interpretation that petitioners urge for the same term in the McCarran-Ferguson Act.

The language from *Shaw* that respondents quote on page 14 of their brief, and upon which they base their claim that the Court has equated "impair" with "direct conflict," was not part of the Court's discussion of the meaning of "impair." The quoted language appears six pages after the end of that discussion and simply states the Court's conclusion respecting the extent to which the state law at issue was preempted under ERISA. Reliance upon that language repeats the logically flawed "inverse preemption" analysis. Unless the restrictive principles of preemption analysis were intended by Congress, this part of *Shaw* is of no relevance.

As the principal effort of its brief, the government attempts to find such an intent to adopt preemption principles in Congress' choice of the words "invalidate," "impair" and "supersede," which the government argues must be understood as coming from and incorporating the preemption jurisprudence of the time. (U.S. Br., pp. 11-19.)[4] The government further supports this argument by reference to the declaration of purpose found in the Act. (U.S. Br.,

[4] Respondents make an abbreviated argument to the same effect. (Resp. Br., pp. 18-20.) On this point, respondents and the government part company with *amicus* NAIC, which recognizes in its brief that "Congress intended to give *broad* support to existing and future state systems for regulating the business of insurance." (NAIC Br., p. 17 (Emphasis in original).)

pp. 19-21.) Although more relevant than the arguments presented by respondents, these efforts also fall short.

(a) *The Source of "Invalidate, Impair or Supersede."* The government urges that the terms "invalidate," "impair" and "supersede" were adopted by Congress from the dissenting opinions in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), and have the special meanings intended by the authors of those dissents. The government further argues that those special meanings were consistent with the meanings generally ascribed to them by the Court in its contemporary decisions.

On this analysis, the government interprets "invalidate" as being synonymous with "preempt," a proposition with which petitioners are in accord. The government finds a similar equivalence between "supersede" and "preempt" noting that the former term was often used by this Court in earlier decisions where the term "preempt" would be used today. None of the cited cases suggest that the term "supersede" must be so constrained, however, and limiting "supersede" to the *de jure* supplanting of state law being discussed in those early cases--excluding the *de facto* supplanting that petitioners urge the Act was also intended to preclude--would render that term entirely duplicative of "invalidate."[5]

[5] The government attempts to deal with this flaw in its argument in a footnote (U.S. Br., pp. 16-17 n.6.), asserting that "invalidate" means preemption *without* a supplanting federal statute while "supersede" means preemption *with* such a statute. This distinction makes no sense in the

(continued...)

With respect to "impair," the government concedes, as it must, that the normal usage meaning of "impair" is as petitioners have urged. (U.S. Br., p. 14.) The government argues, however, that "impair a law" has a different, more specialized meaning that equates with "direct conflict" preemption. The authorities it cites do not support that proposition.

Most of the government's citations do not even address "impairing" laws. For example, *United States v. Waddill, Hollard & Flinn, Inc.*, 323 U.S. 353, 357 (1945), addresses impairment of a lien priority created by federal law by reason of rights vested under state law. *Henry Ford & Son, Inc. v. Little Falls Fibre Co.*, 280 U.S. 369, 377-78 (1930), involved the issue of whether the Federal Water Power Act precluded a claim by an owner of private hydroelectric facilities for impairment of his vested rights in water flow. 280 U.S. at 374-75. *Guaranty Trust Co. v. United States*, 304 U.S. 126, 143 (1938), addressed the question of whether a debtor's right to defend a contested claim was impaired by a treaty of the United States.[6]

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[5](...continued)
context of the McCarran-Ferguson Act which is triggered only if there *is* a federal statute that may supplant state law, leaving the term "invalidate," as the government interprets it, of no possible applicability.

[6] Other decisions use "impair" to address the general effect of the commerce clause on state legislative prerogatives, *e.g.*, *New York, N.H. & H.R.R. v. State of New York*, 165 U.S. 628, 631 (1897), or the effect of state (continued...)

Only two of this Court's decisions cited by the government actually deal with whether a federal statute "impairs" other laws. One of these is *Shaw v. Delta Air Lines*, *supra*, 463 U.S. 85, which as already discussed above, gives "impair" a far broader meaning than "direct conflict." The other is *Rice v. Board of Trade*, 381 U.S. 247, 255 (1947), which similarly uses "impair" in a broader context. That decision speaks both of federal law not being construed "to impair any [applicable] State law" and also of state law that might "in any way impair the federal regulatory scheme." The latter use of impair cannot possibly mean to preempt -- since state law cannot preempt federal regulation -- and seems clearly to refer to a broader range of interactions than a "direct conflict."

In the end, the government's argument on "impair" depends entirely upon the use of that term in Justice Jackson's dissent in *South-Eastern Underwriters* and upon the argument that Justice Jackson effectively defined the term to mean preempted in part and that Congress adopted his definition. Whether the government has correctly read Justice Jackson's intent correctly from the isolated phrase relied upon is dubious at best. More fundamentally, however, the government's assertion that the word "impair" in the McCarran-Ferguson Act comes from Justice Jackson's dissent is demonstrably wrong.

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[6](...continued)
law on what the commerce clause reserves to the federal government generally, *Parker v. Brown*, 317 U.S. 341, 368 (1943).

The government's assertion that the terms "invalidate," "impair" and "supersede" come from the dissents in *South-Eastern Underwriters* is not supported by any authority other than the fact that the terms can be found in those dissents. Indeed, the government does not contend that the terms can, in fact, be traced to those dissents, only that the dissents "appear" to be the source. (U.S. Br. at 13.) Whatever validity the causal inference drawn by the government might have for "invalidate" or "supersede"--and it is doubtful at best--it is irrefutably wrong for "impair."

The term "impair" is taken not from Justice Jackson's dissent but from the bill that was introduced in the unsuccessful effort to enact an earlier version of the McCarran-Ferguson Act in the 78th Congress in 1943, a year before Justice Jackson's dissent was written. The operative language of that bill--which was addressed only to the antitrust laws--provided that those laws should not be construed "to apply to the business of insurance or to acts in the conduct of that business or in any wise to *impair* the regulations of that business by the several States." (H.R. 3270, introduced September 20, 1943) (emphasis added).) The term "impair" as used here cannot be reconciled with the narrow meaning urged by the government. It is plainly a "catchall" term designed to protect state regulation from indirect interference even after all possibility of direct conflict is eliminated by making the federal law entirely inapplicable; and it is clearly the genesis of the same term--accompanied by "invalidate" and "supersede"--that eventually appears in the expanded version of the bill introduced in, and later adopted by, the 79th Congress.

In sum, there is simply no foundation for the government's contention that Congress intended any meaning for "invalidate, impair or supersede" other than that which follows from the ordinary usage of those words.[7]

(b) *The Declaration of Purpose.* The government's more general reference to section 1 of the Act is no more supportive of its limited reading of "invalidate, impair or supersede." To the contrary, section 1 recites that Congress does not intend "to impose *any* barrier to the regulation or taxation of such business by the several States." (Emphasis added.) The notion that the McCarran-Ferguson Act is limited to the *de jure* barrier of federal preemption, and does not include the *de facto* barrier addressed by petitioners, is not merely unsupported by, but affirmatively contrary to, this pronouncement.

2. The Structure of the McCarran-Ferguson Act Does Not Support the "Direct Conflict" Test.

Both respondents and the government argue that the structure of the McCarran-Ferguson Act supports the direct conflict test and both again attack the strawman of field

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[7] Even if the reverse were true, the government's attempt to equate that phrase with the "direct conflict" test would still contain a logical gap. The approach to implied federal preemption enunciated by the Court's most recent decisions -- which define the standard for application of the McCarran-Ferguson Act for the courts that employ the "direct conflict" test -- is of relatively recent origin. *See Cipollone v. Liggett Group*, 505 U.S. 504, 545-48 (1992) (Scalia, J., dissenting). If Congress intended to incorporate contemporary preemption jurisprudence into the Act in 1944, it would not be this recent jurisprudence.

preemption. If Congress intended field preemption, they argue, why does Section 2(b) of the Act contain its specific reference to the antitrust laws? (Resp. Br., pp. 15-16; U.S. Br., pp. 25-26.) The short answer is that already provided above: Petitioners do not contend that field preemption is a viable principle to apply to the McCarran-Ferguson Act.

The argument respecting the antitrust laws advanced by respondents and the government suffers from a deeper problem, however, for it demonstrates a fundamental misconception as to the history of the special provisions addressing the antitrust laws. The most contentious part of the McCarran-Ferguson Act during the Congressional debates was the antitrust exemption, and the bill that originally passed the Senate provided no such immunity to the insurance industry. Section 2(b) of that bill read: "No act of Congress, *except* [the Sherman Act and the Clayton Act], shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . ."[8] 91 Cong. Rec. 488 (January 25, 1945) (emphasis added). The present version of the Act came out of the Conference Committee which modified the Senate's antitrust *exception* to the preclusive effect of the Act by providing, as had the Senate bill, that the antitrust laws would apply to the business of insurance notwithstanding the preclusive effect of section 2(b) but eliminating that exception if the states adopted laws

[8] For the antitrust laws, the preclusive effect of this bill was limited to a moratorium ending a few years later. *Id.* A revised version of this moratorium became section 3 of the Act.

regulating the insurance industry: "Provided, That after June 30, 1948 [the Sherman Act, the Clayton Act and the FTC Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State law." It could not be plainer that, in the eyes of the Congress that enacted the McCarran-Ferguson Act, the business of insurance was to be immune from the antitrust laws because application of those laws would "invalidate, impair or supersede" state regulation.[9]

The issue of whether the federal antitrust laws "invalidate, impair, or supersede" state law has never been a part of this Court's analysis of the McCarran-Ferguson Act's applicability in this area because the broad preclusive intent of Congress was clear. *See, e.g., Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 790 n.17 (1993); *Barnett Bank, N.A. v. Nelson*, 517 U.S. 25, 40-41 (1996). But if the application of the Act to the antitrust laws depended upon whether those laws "invalidate, impair or supersede" state law under the "direct conflict" test, the antitrust immunity that has been recognized for over 50 years might well be jeopardized -- as is illustrated by a recent decision of the district court regarding the antitrust claim in this case that is still pending below but not now before the Court. Reading the Ninth Circuit's decision as requiring the application of the "direct conflict" test even to the antitrust laws, the district court has concluded that application of the antitrust

[9] As the government notes, "Congress knew how to give state law such a broad preemptive effect, and expressly did so with respect to the Sherman Act . . . ." (U.S. Br., p. 25.) The phrase "invalidate, impair or supersede" is how Congress did it.

laws to the business of insurance is not barred by the McCarran-Ferguson Act.[10] It is the "direct conflict" test, not petitioner's interpretation of the Act, that threatens perverse results in this area.

In addition to their argument respecting the antitrust laws, the government and respondents also see structural problems in petitioners' interpretation of the Act arising out of the application of that interpretation to criminal law and taxation, suggesting that petitioners' approach necessarily results in preclusion of federal criminal law and the federal power to tax. (Resp. Br., pp. 47-48; U.S. Br., pp. 26-27.) Not so.

Petitioners urge that federal legislation that does not conflict with state law in its substantive prohibitions must be examined for whether it provides civil procedures or remedies that render the otherwise parallel state law superfluous – *i.e.*, whether the federal legislation "supersedes" the state law, or "impairs" the limits placed on the state remedies by affording a federal claim that overshadows the state law and makes it meaningless from any practical perspective. Critical to this analysis is the fact that state and federal civil law are generally concurrent in that a civil plaintiff can avail itself of whatever body of applicable law is most attractive. This consideration is not present in criminal law or taxation.

As the Eighth Circuit has noted in *United States v. Blumeyer*, 114 F.3d 758, 768 (8th Cir. 1997), there is no

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[10] A copy of the decision of the district court to that effect in this action is set forth in the Appendix hereto.

such overlap of available remedies with respect to criminal law enforcement. Private litigants cannot bring criminal prosecutions, and the governmental authorities who can do so cannot select the body of law they like best. The Department of Justice prosecutes federal crimes. The state equivalents prosecute state crimes. Neither can elect to proceed under the laws of the other sovereign. Accordingly, no federal criminal statute can render superfluous a parallel state criminal statute, and the same reasoning obviously applies to the tax laws inasmuch as each sovereign also levies and collects its own taxes. The federal laws in this area -- other than criminal laws which set different substantive standards -- have no effect on the enforcement of analogous state law and, hence, would not "invalidate, impair or supersede" that law.

As its final structural argument, the government complains that adoption of petitioners' analysis would embroil the courts in impossible debates about the balance of policies embodied in state remedies. (U.S. Br., pp. 27-28.) That argument badly misreads petitioners' position, for petitioners seek to avoid, not encourage, the inappropriate balancing that the government references. If there is a material difference in state and federal remedies, with the federal remedies being the more attractive, the analysis is at an end. As petitioners urged in their opening brief, the federal courts have no business engaging in an assessment of the importance of a state's legislative decision on remedies or in a balancing of those decisions against other considerations.

3. The Legislative History And Caselaw Do Not Support the "Direct Conflict" Test.

As further supposed support of the "direct conflict" test, respondents' brief contains a lengthy discussion of legislative history in an attempt to demonstrate that Congress intended a restrictive interpretation of the McCarran-Ferguson Act. (Resp. Br., pp. 23-33.) The legislative history actually demonstrates the contrary, as petitioners discussed in their opening brief. (Pet. Br., pp. 25-27.)

Respondents begin their discussion of legislative history with citations to historic discussions of insurance fraud, a subject not prominently found in the Congressional debates on the McCarran-Ferguson Act. Respondents then note, correctly but irrelevantly, that the final version of the Act emerged from a conference committee that reconciled the House's desire for near total exemption from federal law with the Senate's somewhat more limited vision. Respondents begin to get to the point in their review of the floor debates, but there respondents look to the remarks of Senators Pepper and Murdock, who were on the *losing* side of the debate in the Senate. Respondents finally turn to the "catch-all" remarks of Senator O'Mahoney already noted in petitioners' opening brief. (Pet. Br., p. 26 n.14.)

The bottom line that respondents draw from this history is that Congress did not intend "field preemption" by the McCarran-Ferguson Act. In fact, the legislative history referenced by respondents might well suggest the contrary, but the point is of no moment. As already noted several times, the continuing attack on "field preemption" is a red herring that is not helpful to analyzing the interpretive question that is actually before the Court. Nor does the

legislative history support a narrow interpretation of the McCarran-Ferguson Act, as respondents alternatively argue. Indeed, respondents' lengthy discussion of the fact that the phrase "invalidate, impair or supersede" was intended as a "catchall" plainly shows an intent that the Act have broad applicability, "catching" all federal legislation other than that specific to the business of insurance.

The caselaw cited by respondents and the government is not to the contrary. The decisions cited by respondents supporting a broad interpretation of RICO are obviously of no relevance; the interpretation of RICO is not before the Court, except for the conceded point that RICO does not "specifically relate" to the business of insurance. Nor do the cited decisions of this Court addressing the McCarran-Ferguson Act -- *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), *Department of Treasury v. Fabe*, 508 U.S.491 (1993) and *Barnett Bank, N.A. v. Nelson*, 517 U.S. 25 (1996) -- support respondents' position here.

Both *Fabe* and *National Securities* dealt principally with the question of what conduct constitutes the business of insurance; *Barnett Bank* dealt with the question of whether the federal statute at issue "specifically relate[d] to the business of insurance." *Fabe* did not address the meaning of "invalidate, impair or supersede" at all, the parties having conceded this element. 508 U.S. at 501. *Barnett Bank* similarly did not address the meaning of that phrase, and the government's attempt to convert the Court's short-hand reference to the Act as an "anti-pre-emption" statute into a definitive characterization is quite a stretch. *National Securities* did address "invalidate, impair, or supersede" but only in passing, noting an absence of conflict between the

substantive prohibitions of Arizona and federal laws because the state and federal law were directed at the protection of different constituencies -- policyholders and shareholders -- a factor that the Court noted was of critical importance: "Different questions would, of course, arise if the Federal Government were attempting to regulate in the sphere reserved primarily to the States by the McCarran-Ferguson Act." *National Securities*, 393 U.S. at 463. The Court did not there address the issue here presented -- the consequences of differing remedies when state and federal law are directed at protecting the *same* constituencies -- and the decision cannot be read as an attempt by the Court to supply a definition of universal application for the "invalidate, impair, or supersede" phrase that is critical to the issue now presented.

B. The Argument That RICO "Supplements" State Law Actually Demonstrates That RICO "Impairs" Or "Supersedes" State Law.

As an alternative to their arguments in defense of the "direct conflict" test, respondents, the government and the other *amici* also argue that RICO survives an analysis under a conventional interpretation of "invalidate, impair or supersede" because RICO "supplements" state law by providing civil remedies not available under state law. This argument is simply the assertion that they prefer RICO to the laws enacted by the several states dealing with the same conduct. Having lost their efforts to obtain RICO-like remedies from the state legislatures, or to have Congress specifically apply RICO to the business of insurance, they do

not want to be relegated to the remedies those state legislatures have provided.[11]

The plea that state remedies are inadequate, or that RICO is a critical federal tool in combating what respondents see as rampant corruption in the insurance industry,[12] is

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[11] Respondents argue that Nevada's "little RICO" act does reach the conduct at issue here and the district court's contrary determination was erroneous. (Resp. Br., pp. 5-6 and 34 n.29.) In so arguing, respondents rely upon: (i) the fact that a deputy attorney general drafted an indictment that was never filed; and (ii) the inclusion of obtaining money under false pretenses and of violation of NEV. REV. STAT. § 686.291(1)(b) -- prohibiting false claims -- as predicate acts. The drafting of an indictment never filed obviously proves nothing, and the conduct at issue here -- allegedly improper withholding of benefits -- does not constitute either of those predicate acts.

[12] Respondents support this public policy argument by referencing the well-publicized problems of Columbia/HCA Healthcare, which company respondents assert "Humana simply merged with, and changed its name to . . .." (Resp. Br., p. 45.) While petitioners are loathe to dignify this argument by addressing it at all, or to allow the inference that respondents' accusations directed at Columbia/HCA Healthcare are meritorious, they cannot let the argument pass without noting that respondents know that its predicate is untrue. As respondents know from proceedings below, petitioners did not merge with Columbia/HCA Healthcare. Although certain hospital assets of Humana were eventually acquired by Columbia/HCA Healthcare -- giving Columbia/HCA Healthcare an interest in this litigation, as

(continued...)

more properly directed to Congress than to this Court. Indeed, it was unsuccessfully advanced to the 78th Congress by the Justice Department when the predecessor to the bill that eventually became the McCarran-Ferguson Act in the 79th Congress was first introduced:

> The Department of Justice also urged that the Federal Government should interfere with State regulation where the latter is not adequate according to a standard determined by the Department of Justice. The committee is not impressed by such argument.

S. Rep. No. 78-1112, at 5 (1944). Only Congress can reverse that judgment.

CONCLUSION

For the reasons discussed herein and in the opening brief of petitioners, the decision below of the United States Court of Appeals for the Ninth Circuit should be reversed and this action remanded with instructions that the prior decision of the district court be affirmed.

October 23, 1998

Respectfully submitted,

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Counsel of Record for
Petitioners

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[12](...continued)
disclosed in petitioners' opening brief -- Humana Inc., is an independent, publicly-held company traded on the New York Stock Exchange.

APPENDIX

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APPENDIX

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September 21, 1998 Order of the United States District Court for the District of Nevada in *Forsyth v. Humana*

APPENDIX

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

No. CV-S-89-0249-DWH(LRL)

ORDER

(Filed September 21, 1998)

MARY FORSYTH, et al.,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation, HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

This case is on remand from the Ninth circuit, *Forsyth v. Humana, Inc.* 114 F.3d 1467 (9th Cir. 1997). It was assigned to this Court after Judge Pro recused himself in fall, 1997. Before the Court is defendants' motion for summary judgment on the antitrust claims. (#996, opp. #1001, errata to opp. #1003, reply #1005.) Also before the Court is a "supplemental" memorandum in support of summary judgment (#1022, opp. #1023, reply #1025); this supplemental memorandum actually raises a new ground for summary judgment.

There are two groups of plaintiffs: employer purchasers of group health insurance policies issued by Humana Health Insurance of Nevada ("Premium Payors"), and employee beneficiaries of those who made co-insurance payments for care received ("Co-Payors").

The Co-Payors received care from Humana Hospital-Sunrise ("Sunrise"), an acute care facility owned by defendant Humana Inc. Humana Insurance was obligated to pay 80% of the employee's hospital charges over and above a designated deductible, and the Co-Payors were to pay the remaining 20%. However, unknown to plaintiff, Humana Insurance had a discount arrangement with Sunrise Hospital, resulting in Humana Insurance ultimately paying significantly less than 80% of Sunrise's charges and the Co-Payors paying more than the supposed 20%

The Co-Payors contend Human Insurance breached its contract and violated ERISA by failing to pass along Sunrise Hospital's discounts in the form of reduced co-payments. They also claim violation of ERISA for breach of fiduciary duties, engaging in prohibited transactions and retaining excessive compensation. Both plaintiff groups claim

violation of Section 2 of the Sherman Antitrust Act, 15 U.S.C. § 2, and a scheme to defraud in violation of RICO, 18 U.S.C. §§ 1961-1968.

The ERISA portion of the case has been disposed of. The Ninth circuit affirmed Judge Pro's grant of summary judgment for defendants on the fiduciary duty claim, but also affirmed summary judgment in favor of plaintiffs on the breach of contract claim. The Court also affirmed the computation of damages, i.e., all amounts they were forced to pay over and above their contractual co-payment obligations. Only determination of the specific amount of ERISA damages remains.

The antitrust claims will be discussed more fully below, but, essentially, the Ninth Circuit found an issue of fact as to the definition of the relevant market. 114 F.3d at 1477. The court also found three instances of impermissibly anticompetitive conduct: Sunrise's refusal to provide Level III neonatal care (of which it was the only hospital certified to provide), Sunrise's diversion of indigent or low-paying critical care patients to other hospitals, and Humana's alleged threats to physicians who did not support its monopoly. 114 F.3d 1472-73.

STANDARD

Summary judgment should be granted if the evidence, read in the light most favorable to the nonmoving party, demonstrates that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Taylor v. List*, 880 F.2d 1040, 1044 (9th Cir. 1989). "There is no genuine issue of

material fact if the party opposing the motion 'fails to make an adequate showing sufficient to establish the existence-of an element essential to that party's case, and on which that party will bear the burden of proof at trial.'" *Taylor*, 880 F.2d at 1045 (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986)). Nor is there a genuine issue of fact if a rational trier of fact could not find in favor of the party opposing the motion for summary judgment. *Taylor*, 880 F.2d at 1045 (citing *Matsushita Elec. Indus. v. Zenith Radio*, 475 U.S. 574, 586 (1986)). Finally, conclusory allegations that are unsupported by factual data cannot defeat a motion for summary judgment. *Taylor*, 880 F.2d at 1045.

I. Market Power

Defendants' first argument is that they are entitled to judgment on the issue of market power, because even in the smaller submarket alleged by plaintiffs, defendants have less than 60% of the market share. 15 U.S.C. § 2 provides:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony....

A. Monopolization

To show monopolization, plaintiff must show (1) possession of monopoly power in the relevant submarket; (2) willful acquisition or maintenance of that power; and (3) causal antitrust injury. *Pacific Express, Inc. v. United Airlines, Inc.*, 959 F.2d 814, 817 (9th Cir. 1992).

As noted by the Ninth Circuit above, a circumstantial showing of monopoly power requires plaintiff to: (1) define the relevant market; (2) show that defendant owns a dominant share of that market and (3) show that there are significant barriers to entry into the market and existing competitors lack the capacity to increase their output in the short run. 114 F.3d at 1375.

The definition of the relevant market is a factual inquiry and the court may not weigh evidence or judge credibility. *Rebel Oil Co., Inc. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1435 (9th Cir. 1995). The relevant market is the group of sellers who have the actual or potential ability to deprive each other of significant levels of business. *Thurman Indus. v. Pay N Pak Stores*, 875 F.2d 1369, 1374 (9th cir. 1989).

On its review of this case, the Ninth Circuit found there may be a relevant submarket in the major for-profit acute care hospitals in Clark County. A submarket exists if it is sufficiently insulated form the larger market so that supply and demand are inelastic with the larger market. *Morgan, Strand, Wheeler & Briggs v. Radiology, Ltd.*, 924 F.2d 1484, 1490 (9th Cir. 1991). Specifically, the Ninth Circuit found that five other hospitals--Boulder City Hospital, Hospital of North Las Vegas, St. Rose De Lima Hospital, University Medical Center and Women's Hospital--possibly should not have been included in the submarket.

Defendants argue that, even if the relevant market is conceded, Sunrise Hospital did not have enough market share to establish monopoly power. Market power is the power to force a purchasers to do something he would not do in a competitive market. It has been defined as the ability of a single seller to raise price and restrict output.

Eastman Kodak v. Image Technical Services, 504 U.S. 451, 464 (1992). Monopoly power may be inferred from a "predominant" share of the market. *United States v. Grinnell Corp.*, 384 U.S. 563, 571 (1966) (finding monopoly power in 87% of the market). Learned Hand's famous formulation in *United States v. Aluminum Co. of American*, 148 F.2d 416, 424 (2nd. Cir. 1945) was 90% is "enough" but 60-64% is "doubtful."

Defendants claim Sunrise's share of the alleged submarket is no more than 50-55%, and that share declined by 4% during the relevant period. #996 at 8. Plaintiffs claim Sunrise had 60-65% of the market. Plaintiffs also claim Sunrise had "close to" 60% of the gross patient revenues, excluding medicare and medicaid. #1001 at 6. Plaintiffs then claim these are sufficient for a finding of monopolization when coupled with the other factors such as monopoly on Level III neonatal services and a strong barrier to entry in the form of certificate of need regulations.

However, economic factors besides market share may be taken into consideration. Thus, in *Pacific Coast Agric. Export Assn v. Sunkist Growers*, 526 F.2d 1196, 1204 (9th Cir. 1975), *cert. denied*, 425 U.S. 959 (1976), the Ninth Circuit held that control over the supply of oranges and the relatively small size (no single competitor over 18% of market) of competitors in the distribution market made it possible for the jury to find market power in the distribution market where Sunkist had a market share from 45-70% over the relevant period.

In *Kodak and Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984), the Supreme Court recognized economic factors relevant to the current inquiry. The *Kodak*

court noted such factors are important where rational economic explanations "may not accurately explain the behavior of the [market]." 504 U.S. at 473. In *Kodak*, the Court noted that Kodak's practice of pricing service and parts separately for the initial sale of its machines prevented purchasers from obtaining an accurate estimate of the "life cycle" cost of a photocopier; thus, Kodak could charge supra competitive prices as the sole supplier of parts and service, despite having only a 2-23% share of the photocopier market. *Id.* at 472-73; *Image Technical Serv., Ins. V. Eastman Kodak Co.*, 903 F.2d 612, 616 n.3 (9th Cir. 1990) (noting that Kodak had market share of 23% of the copier market, 20% of the micrographic equipment market, and less than 2% of the plain paper copier market). Also, because of the high initial outlay in buying the machines, customers were precluded from switching vendors. *Id.* at 477. Thus, the court identified two factors affecting elasticity of demand: information deficiencies and high switching costs. In *Jefferson Parish*, the Court did not find market imperfections sufficient to show monopolization with a 30% share of a market. However, the Court noted that the imperfections at issue--lack of consumer incentive to compare costs among hospitals and lack of adequate information with which to compare quality among hospitals--could create antitrust liability if they were accompanied by restraints on a consumers' choices for healthcare providers. 466 U.S. at 27. Also, in examining the exclusive contract for anesthesiology, the Court implied that elasticity of supply could be affected by an alleged monopolist that lowers the

ability of sellers to enter the market.[1] *See id.* at 7-8 and nn.

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[1] Other cases have relied heavily on the factor of barriers into the market. For instance, *Reazin v. Blue Cross and Blue Shield of Kansas*, 899 F.2d 951, 969-72 (10th Cir. 1990) upheld a jury's finding of monopoly power where the relevant market share was between 47%-62%. The court noted the following factors as relevant, in light of less-than-presumptive market share: Blue Cross had certain historical advantages (it was the first health care insurer in the state, it was chartered under special legislation), Blue Cross had power over price and power to exclude competition (its "most favored nations clause" hindered the development of "alternative delivery systems" [Blue Cross's first real competition]), barriers to entry were not "insubstantial" (this finding was based on the fact that there were over 200 insurers and no one approached Blue Cross's dominance of the market), and the existence of "peculiar characteristics of the health care financing market in Kansas" such as Blue Cross's unique ability for a period to contract directly with hospitals and the widespread impression that Blue Cross alone had the legislature's "special imprimatur."

In Syufy Enterprises v. American Multicinema, Inc., 793 F.2d 990, 995-96 (9th Cir. 1986), the court upheld a finding of monopoly power with a 60-69% share of the market in theaters. The court relied on fragmentation of competition, finding that during the relevant period no competitor had over 24.7% of the market, which ranged sometimes to as low as 12%. The court also relied on barriers to entry, finding that exclusive runs of movies were a deterrent to the establishment of more theaters.

7-8. Thus, under these two cases, there are three relevant market imperfections affecting demand in healthcare: (1) information deficiencies; (2) high switching costs; and (3) financing arrangements that reduce price competition, if accompanied by restrictions on consumers' choices of products. The Court should also examine elasticity of supply, as determined chiefly by barriers to entry into the market.

Analysis of these cases shows that no market power of 60%, on its own, has been deemed enough to given rise to a monopoly. Thus, the analysis hinges on market imperfections. There is great potential for such imperfections in the market for health care services. In the present case, plaintiffs allege that despite a falling market share, Sunrise had the highest profits of any hospital in Nevada, which had the highest profits in the country. In the

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In Metro Mobile CTS, Inc. v. Newvector Communications, Inc., 892 F.2d 62,63 (9th Cir. 1989), the court upheld a finding of no monopoly power in part because there were no significant barriers to entry. Regulations required only that entrants into the market have sufficient financial backing, which plaintiff had.

One treatise argues that after market share, barriers may be the most important factor. Irving Scher, *Antitrust Advisor*, 4th ed., § 1.26. *See also Los Angeles Land Co. V. Brunswick Corp.*, 6 F.3d 1422, 1426-27 (9th Cir. 1993) (near 100% market with no barriers not enough for a monopoly); *U..S. v. Syufy*, 903 F.3d 659, 664-69 (same); *Energex Lighting v. North American Philips Lighting*, 656 F.Supp 914, 921 (SDNY 1987) (low market share with strong barriers enough to survive summary judgment).

health care market, where employers typically pay for health insurance, consumers lack incentive to compare prices. Further, insurers' lack of incentive to provide clear pricing information creates an information deficiency. Consumers thus may be injured by paying higher premiums and co-payments.

Also, regarding financing arrangements coupled with restricted choice, by splitting the payor from the consumer, insurers may exploit the market. This is because the consumer/insureds had no other choice for level III neonatal care, but they were not the parties ultimately responsible for paying the premiums. Furthermore, the alleged threats to doctors recommending other hospitals could have the effect of restricting consumer choice.

The alleged threats to physicians also could affect supply. This is in effect a barrier into the market for other hospitals. Also, "dumping" indigent patients could be a barrier into the submarket because, if the relevant market eventually is defined as the major for-profit acute care hospitals in Nevada, then sending low-paying patients to other hospitals could preclude those hospitals from becoming profitable enough to enter the submarket. Finally, there is the issue of the certificate of need regulations closing access to the submarket.

In sum, the market imperfection factors made this case very close. In such a close question, it is important to note that the Supreme Court has stated its distaste for resolving antitrust cases on "formalistic distinctions rather than market realities." *Kodak*, 504 U.S. at 466. The preference in antitrust law is to "resolve antitrust claims on a case-by-case basis...." *Id.* (citations omitted). Thus, this case should

proceed to trials so that the finder of fact can assess all of the relevant "market realities."

II. The Premium Payors' Standing

Defendants argue that because there is no evidence of a monopoly in the health insurance market, the Premium Payors have no claim for premium overcharges. However, the Ninth Circuit's opinion clearly states "[t]hese high prices translated into higher copayments and premium payments. 114 F.3d at 1478. The cases cited by the Ninth Circuit--*Blue Shield of Virginia v. McCready*, 457 U.S. 465 (1982) and *Reiter v. Sonotone Corp.*, 442 U.S. 330 (1979)-provide that consumers have standing to sue under antitrust laws when they suffer a price increase resulting from anticompetitive conduct; as purchasers of health insurance, the Premium Payors were consumers and have such standing.

III. The McCarran-Ferguson Act

Defendants argue plaintiffs' antitrust claims are preempted by the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq., which is an "anti-preemption" statute stating that no acts of Congress shall preempt state law "regulating the business of insurance" unless the federal law specifically relates to the business of insurance. The Ninth Circuit above found that the McCarran-Ferguson Act did not bar application of RICO to the kickback scheme alleged in this case. 114 F.3d at 1480.

Applicable subsections of the McCarran-Ferguson Act read:

15 U.S.C. § 1012(b):

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance...unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the [antitrust acts] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1013(b):

> Nothing contained in the McCarran-Ferguson Act shall render the Sherman Act inapplicable to an agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation.

In the case above, the Ninth Circuit stated that the McCarran-Ferguson Act precludes a federal statute if:

> (1) The federal statute does not specifically relate to the business of insurance; (2) the acts challenged under the statute constitute the business of insurance; (3) the state has enacted a law or laws regulating the challenged act and (4) the state law would be superceded, impaired or invalidated by the application of the federal statute.

114 F.3d at 1479. Neither side recognizes that the rest must be applied "from the ground up." The court cannot utilize the Ninth Circuit's McCarran-Ferguson/RICO analysis because (1) the relevant federal law in that analysis was RICO, not the Sherman Act, (2) the acts challenged were fraud relating to the kickback scheme, which the Ninth

Circuit explicitly stated provided no basis for antitrust relief and (3) the state law was analyzed as it related to RICO.

As a preliminary matter, the court notes there appears to be some confusion as to whether the four part test outlined above applies to antitrust analysis. In their argument concerning the fourth prong of that test, defendants claim the holding by the Ninth Circuit on the RICO issue "is not applicable to plaintiffs' antitrust claims, since the McCarran-Ferguson test does not require invalidation or impairment." #996 at 14. This assertion is perplexing. Defendants continue by detailing the history of the McCarran-Ferguson Act, and its passage specifically to limit the application of the Sherman Act to the business of insurance. As the Supreme Court stated shortly after the passage of the Mccarran-Ferguson Act. "(o)bviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429 (1946). The Court later stated "Congress was mainly concerned with the relationship between insurance ratemaking and the antitrust laws, and with the power of the States to tax insurance companies." 393 U.S. 453, 457 (1969). However, while the McCarran-Ferguson Act does mention antitrust regulation specifically, it was passed with a general concern for federal incursion on an activity traditionally regulated by the States. The declaration of policy of the McCarran-Ferguson Act, 15 U.S.C. § 1011, states "silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States;" this does not single out the Sherman Act or antitrust law. Thus, the same four part test used to assess

any federal regulation's incursion on state regulation must be used to assess incursion by the Sherman Act.

Regarding the first prong of this test, it is clear that the Sherman Act does not specifically relate to the business of insurance.

Regarding the second prong, plaintiffs argue that the acts challenged do not constitute the business of insurance because they "take place in the hospital market, not the health insurance market." #1011 at 11. By making this argument, plaintiffs undermine their own standing to bring this suit. Plaintiffs can bring this case because they are purchasers and co-payors in the insurance market, and the alleged anticompetitive acts at Sunrise-a Humana controlled hospital-raised prices. 114 F.3d at 1478. In analyzing the RICO claims under the McCarran-Ferguson test, the Ninth Circuit stated "[t]he acts the plaintiffs challenge are analytically equivalent to the overcharging for premiums alleged in Merchants Home." 114 F.3d at 1480. The same conclusion applies here because the anticompetitive acts result in overcharging for premiums.

Regarding the third prong, court finds that Nevada has enacted a law regulating the challenged acts. NRS § 686A.010 states that the purpose of the Trade Practices and Frauds; Financing of Premiums Act (Act) is to regulate by defining or determining "all such practices in this state which constitute unfair methods of competition...." As noted by the Ninth Circuit, under the Act, the Nevada Commissioner of Insurance has "exclusive jurisdiction" to regulate the trade practices of the business of insurance. NRS § 686A.015. Finally, NRS § 686A.170 states:

> 1. If the commissioner believes that any person engaged in the insurance business is in the conduct of such business engaging in this state in any method of competition or in any act or practice not defined in NRS 686A.010 to 686A.310, inclusive, which is unfair or deceptive and that a proceeding by him to respect thereto would be in the public interest, the commissioner shall, after a hearing of which notice and of the charges against such person are given him, make a written report of his findings of fact relative to such charges and serve a copy thereof upon such person and any intervener at the hearing.

This general prohibition against unfair competition is sufficient, when combined with the statement of "exclusive jurisdiction," to show that Nevada has enacted a law regulating monopolistic conduct.

The fourth factor is whether the application of the Sherman Act would "invalidate, impair, or otherwise supersede Nevada's legislation." 114 F.3d at 1480. In the case above, the court found that there was "some symmetry between RICO's private right of action and Nevada's administrative scheme under NRS chapter 686A]." *Id.* Similarly, in this case, plaintiffs have a private cause of action under the Sherman Act, and there are also administrative remedies under chapter 686A. The court can find no greater conflict between the NRS and the Sherman Act than exists between the NRS and RICO. Therefore, the court is bound to follow the Ninth Circuit's holding that

"[t]this symmetry, however, does not create a conflict between federal and state law."[2] 114 F.3d at 1480.[3]

IV. Antitrust Damages

Defendants move for summary judgment on the ground that plaintiffs have failed to provide sufficient evidence to permit the jury to make a reasoned estimate of damages caused by the alleged unlawful conduct. However, the Ninth Circuit's opinion provides an adequate framework for deciding damages. Plaintiffs may have been forced to pay higher copayment and premium payments; those increases

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[2] The court is mindful of the fact that the RICO portion of this case has been taken up on certiorari by the Supreme Court. However, the present state of the law in the Ninth Circuit dictates this result.

[3] The court also notes that even if the McCarran-Ferguson Act were to preempt federal regulation by the Sherman Act, 15 U.S.C. § 1013(b) may be applicable. § 1013(b) provides:

> Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, intimidate, or act of boycott, coercion, or intimidation.

The language of this section is broad and unqualified, and it covers any act or agreement amounting to boycott, coercion, or intimidation. *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 98 S.Ct. 2923 (1978). In the present case, the alleged threats to doctors who referred patients to hospitals other than Sunrise could be considered coercion or intimidation.

"would constitute antitrust injury of the type the antitrust laws were designed to prevent." 114 F.3d at 1478. When calculating the antitrust damages, the court stated "the jury will be faced with the difficult task of separating the antitrust damages from the damages resulting from Humana's kickback scheme." *Id.* With these guidelines in mind, the plaintiffs will be allowed to put on evidence of damages at trial. After trial, defendants may renew their motion on the sufficiency of the evidence.

Further, once antitrust injury and causation have been shown, plaintiffs' burden in establishing damages greatly lessens. As the Supreme Court has stated, once violation has been shown, not to allow damages because of uncertainty would "be an inducement to make wrongdoing so effective and complete in every case as to preclude any recovery, by rendering the measure of damage uncertain." *Bigelow v. RKO Radio Pictures, Inc.*, 327 U.S. 251, 264-65 (1981). A reasonable estimation allows plaintiff to recover damages even if they are merely an approximation. *D&S Redi-Mix v. Sierra Redi-Mix & Contracting Co.*, 692 F.2d 1245, 1249 (9th Cir. 1982). Once injury and causation are demonstrated, the trier of fact will be permitted to "make a just and reasonable estimate of the damage based on relevant data, and render its verdict accordingly," *Bigelow* at 265. In the present case, the Ninth Circuit has identified three areas of causal antitrust injury, and it has stated that damages, while being difficult to calculate, are determinable. 114 F.3d at 1478. Defendants' motion will be denied on this point.

V. The Attempted Monopolization Claims

Finally, defendants supplemental memorandum moves for summary judgment on the rather common sense notion that plaintiffs, as consumers and users of health insurance, cannot state a claim for attempted monopolization because they would sustain no damage unless the monopoly in fact existed. #1022. Plaintiffs have provided no viable argument on this point. Because the Ninth Circuit identified plaintiff's damages as stemming from higher co-payments and premiums caused by anticompetitive conduct, it is impossible to have any such injury without that anticompetitive conduct. Thus, summary judgment on the claims of attempted monopolization will be granted. *See In Re Air Passenger Computer Reservation Systems*, 727 F. Supp. 564, 569 (C.D. Cal. 1989) (digesting relevant cases and concluding that consumers are damaged by monopoly, not attempted monopoly), *aff'd sub nom.*, 948 F.2d 536 (1991). Summary judgment will be granted on the claims of attempted monopolization.

Accordingly, **IT IS HEREBY ORDERED** that defendants' motion for summary judgment (#996, 1022) is GRANTED IN PART. The motion in GRANTED as to plaintiffs' claims of attempted monopolization (i.e., the argument raised in the supplemental memorandum, #1022). In accordance with this order it is DENIED in all other respects.

DATED: This 15th day of September, 1998.

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UNITED STATES DISTRICT JUDGE

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Supreme Court, U.S.
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No. 97-303

In the Supreme Court of the United States

OCTOBER TERM, 1997

HUMANA INC., AND
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PETITIONERS

v.

MARY FORSYTH, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

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38 pp

QUESTION PRESENTED

The McCarran-Ferguson Act states that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance." The question presented is whether the McCarran-Ferguson Act precludes a private party from bringing suit under the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1961 *et seq.*, to obtain a federal remedy of treble damages, 18 U.S.C. 1964(c) (Supp. II 1995), for a pattern of mail fraud allegedly perpetrated by a healthcare insurer, where state insurance law does not provide a treble damages remedy.

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TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

INTEREST OF THE UNITED STATES

The United States prosecutes criminal activity in the insurance business under the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1961 *et seq.*, and other criminal statutes, and has obtained civil injunctions against such activity under 18 U.S.C. 1345. The United States also enforces the Fair Housing Act, 42 U.S.C. 3601 *et seq.*, and other civil rights statutes touching upon insurance practices. In response to this Court's invitation, the Solicitor General filed a brief at the petition stage on behalf of the United States as amicus curiae.

STATEMENT

1. Prior to this Court's decision in *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), it often had been assumed that "[i]ssuing a policy of insurance [wa]s not a transaction of commerce," *Paul* v. *Virginia*, 75 U.S. (8 Wall.) 168, 183 (1869), and consequently that federal law did not apply to the business of insurance. *Department*

of Treasury v. *Fabe*, 508 U.S. 491, 499 (1993); *St. Paul Fire & Marine Ins. Co.* v. *Barry*, 438 U.S. 531, 538-539 (1978). In *South-Eastern Underwriters*, however, this Court held that an insurance company doing business across state lines was engaged in interstate commerce; it further held that, as a result, the Sherman Act applies to the business of insurance. 322 U.S. at 539-561.

That decision triggered concern about the extent to which federal law might pre-empt state insurance regulation. *St. Paul Fire & Marine*, 438 U.S. at 539. As the dissenting opinions in *South-Eastern Underwriters* explained, the Sherman Act itself would (under the Court's decision) pre-empt certain state insurance laws: The "statutes of at least five states will be invalidated by the decision as in conflict with the Sherman Act." 322 U.S. at 581 (Stone, C.J., dissenting); see *id.* at 586-587, 590-591, 595 (Jackson, J., dissenting). The dissenting opinions also raised the specter that, because the Court had held the sale of insurance to be interstate commerce, state regulation might be displaced entirely under the Court's dormant Commerce Clause jurisprudence. See *id.* at 581 (Stone, C.J., dissenting) ("The extent to which still other state statutes will now be invalidated as in conflict with the commerce clause has not been explored in any detail."); see also *id.* at 586-587 (Jackson, J., dissenting) (warning that the Commerce Clause has the effect of "restricting state power").

In response to those concerns, and to lend "support to the existing and future state systems for regulating and taxing the business of insurance," Congress in 1945 enacted the McCarran-Ferguson Act, 15 U.S.C. 1101 *et seq.* *Prudential Ins. Co.* v. *Benjamin*, 328 U.S. 408, 429 (1946). Section 1 of the Act, the Act's statement of policy, "declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such

business by the several States." 15 U.S.C. 1011. Sections 2 through 5 of the Act implement that policy, addressing each of the concerns raised in the *South-Eastern Underwriters* dissents. 15 U.S.C. 1012-1014.

In Section 2(a) of the Act, Congress put its imprimatur on state regulation of insurance, ensuring that Congress's failure to regulate interstate insurance transactions would not be construed under the dormant Commerce Clause as barring state regulation. "The business of insurance, and every person engaged therein," Section 2(a) declares, "shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012(a). And to mitigate the immediate effect of the antitrust laws (and certain other specifically identified federal laws) on state regulatory regimes, Congress in Sections 2(b) and 3 imposed a partial moratorium on their application to the business of insurance for four years, and made them generally applicable thereafter only to the extent that the insurance business had not been regulated by the State. See 15 U.S.C. 1013(a) (Sherman Act, Clayton Act, Robinson-Patman Act, and FTCA "shall not apply to the business of insurance" until "June 30, 1948"); 15 U.S.C. 1012(b) (Sherman Act, Clayton Act, and FTCA "shall be applicable to the business of insurance to the extent that such business is not regulated by State Law"); see also 15 U.S.C. 1013(b) (McCarran-Ferguson Act does not preclude antitrust actions with respect "to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation").

Most pertinent here, in Section 2(b) Congress addressed the concern that other federal statutes—not yet enacted or not specifically identified in the McCarran-Ferguson Act—might be read to displace state insurance regulation

and taxation. To prevent that, Section 2(b) creates a special rule of statutory construction:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

15 U.S.C. 1012(b). The McCarran-Ferguson Act is thus designed to "remov[e] obstructions" to state insurance regulation and taxation "which might be thought to flow from [Congress's] own power, whether dormant or exercised, except as otherwise expressly provided in the Act itself or in future legislation." *Prudential*, 328 U.S. at 429-430.

2. In 1970, Congress enacted the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. 1961 *et seq.*, as part of an effort to eradicate organized crime. See Organized Crime Control Act of 1970, Statement of Findings and Purpose, Pub. L. No. 91-452, 84 Stat. 922. In relevant part, RICO makes it unlawful for "any person employed by or associated with any enterprise engaged in [or affecting] interstate or foreign commerce, to conduct or participate * * * in the conduct of the enterprise's affairs through a pattern of racketeering activity." 18 U.S.C. 1962(c). Racketeering activity includes "any act * * * 'indictable' under numerous specific federal criminal provisions, including mail and wire fraud." *Sedima, S.P.R.L.* v. *Imrex Co.*, 473 U.S. 479, 481 (1985); see 18 U.S.C. 1961(1)(A).

The United States may bring criminal charges or initiate civil proceedings against RICO violators. See 18 U.S.C. 1963 (criminal penalties), 1964(a) and (b) (civil proceedings by the Attorney General). In addition, RICO provides a private right of action under which "[a]ny person injured in his business or property by reason of a violation of" RICO may bring suit to recover "threefold" the damages sustained plus "the cost of the suit, including a reasonable attorney's fee." 18 U.S.C. 1964(c).

3. Respondents are certain beneficiaries of group health insurance policies issued by petitioner Humana Health Insurance of Nevada ("Humana Insurance"). Pet. App. 2a.[1] Under those policies, Humana Insurance was obligated to pay 80% of a beneficiary's hospital charges over and above a designated deductible amount; the beneficiary was to pay the remaining 20% as a co-payment. *Ibid.* Respondents allege that, beginning in 1985, petitioners perpetrated a massive fraud to shift payment obligations from themselves to policy beneficiaries.

Respondents charge that Humana Insurance and Humana Sunrise Hospital (Sunrise Hospital) (an acute care facility in Nevada owned and operated by petitioner Humana, Inc.) entered into a secret arrangement under which Humana Insurance obtained discounts of between 40% and 96%. Pet. App. 2a-4a, 43a. According to respondents, the entire discount was credited toward Humana Insurance's 80% obligation. *Id.* at 3a-4a, 43a. Policy beneficiaries, in contrast, continued to be billed for co-payments as though Sunrise Hospital were charging the full, undiscounted rate. *Id.* at 3a-4a. As a result, those making co-payments were misled into paying far more than 20%—and Humana Insurance paid far less than 80%—of total charges. For example, Humana Insurance might receive an 89% discount on a hospital bill of $5,000, and thus receive a bill for just $550 (11% of $5,000). The co-payor, however, would pay 20% of the undiscounted rate of $5,000, or a total of $1,000. See Pet. App. 57a. Thus, of the $1,550 charged by Sunrise Hospital, $1,000 or nearly 65% would be paid by the policy beneficiary, while only $550

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[1] The original plaintiffs included not only the beneficiaries of the insurance policies, but also their employers, who purchased the policies. Pet. App. 2a. The district court, however, granted summary judgment for petitioners with respect to the employer/purchaser RICO claims, *id.* at 21a, 86a-87a, 89a-90a, and the court of appeals affirmed, *id.* at 26a-28a, 30a. Respondents have not sought review of those decisions, and the claims of the employer/purchasers thus are not before this Court.

or just over 35% would be paid by Humana Insurance. *Ibid.* Under respondents' understanding of the co-payment provision, the beneficiary should have paid just 20% of total charges, or $310, and Humana Insurance should have paid 80% of total charges, or $1,240. *Ibid.*

4. Respondents brought suit in the United States District Court for the District of Nevada, seeking recovery under several causes of action, including RICO. Respondents charge that petitioners engaged in a pattern of racketeering activity consisting of mail, wire, radio, and television fraud, and that the frauds deceived respondents into making excessive co-payments. Pet. App. 20a-21a; J.A. 126-131.

The district court granted petitioners' motion for summary judgment on the RICO claims. Pet. App. 21a, 91a-96a. The McCarran-Ferguson Act, the district court ruled, precludes the application of a federal statute if (1) the statute does not "specifically relate" to the business of insurance, (2) the acts challenged under the statute constitute the business of insurance, (3) the State has enacted laws regulating the business of insurance, and (4) state law would be superseded, impaired, or invalidated by application of the federal statute. *Id.* at 91a-92a. After concluding that the first three factors were satisfied, the court noted that Nevada has a comprehensive scheme of insurance regulation, *id.* at 93a-94a, under which the Nevada Commissioner of Insurance has "exclusive jurisdiction in regulating the subject of trade practices in the business of insurance." Nev. Rev. Stat. § 686A.015 (1997) (quoted in Pet. App. 93a). Because RICO's private remedies, including its treble damages provision, far exceed state insurance law penalties for the same conduct, the court concluded that permitting policy beneficiaries such as respondents to seek relief under federal law would "invali-

date, impair, or supersede" Nevada law within the meaning of the McCarran-Ferguson Act. *Id.* at 95a.[2]

5. The court of appeals reversed in relevant part. Relying on its decision in *Merchants Home Delivery Service, Inc.* v. *Frank B. Hall & Co.*, 50 F.3d 1486 (9th Cir.), cert. denied, 516 U.S. 964 (1995), and in accord with the reasoning of decisions of the First, Fourth, Fifth, and Seventh Circuits, see pp. 22, 26, *infra*, the court of appeals rejected the notion that the existence of state regulation is, by itself, sufficient under the McCarran-Ferguson Act to preclude application of federal law. Instead, the court of appeals held that federal law does not "invalidate, impair, or supersede" state insurance law within the meaning of the Act unless federal law conflicts with state law. Pet. App. 24a-25a. Mere overlap in the coverage of Nevada insurance law and RICO, it held, "does not create a conflict between federal and state law" since neither law prohibits conduct that the other compels or permits. *Id.* at 25a. Accordingly, the court of appeals reversed and remanded in relevant part. *Ibid.*

SUMMARY OF ARGUMENT

A. When Congress enacted the McCarran-Ferguson Act in response to this Court's decision in *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), it used the terms "invalidate, impair, or supersede [state] law" in the same sense as had the *South-Eastern Underwriters* dissents—to mean, in modern parlance, "to pre-empt." That was the prevailing legal understanding of those terms when the McCarran-Ferguson Act was passed, as evidenced by their use in this Court's cases, and by their use by Congress itself. Thus, far from creating a special rule to prevent the application of federal law with incidental effects on state insurance regulation, Section 2(b) of the McCarran-Ferguson

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[2] The district court also granted summary judgment on a number of other claims, none of which is before this Court.

Act, 15 U.S.C. 1012(b), is "a special federal anti-pre-emption rule, which provides that a federal statute will not pre-empt a state statute enacted 'for the purpose of regulating the business of insurance'—unless the federal statute 'specifically relates to the business of insurance.'" *Barnett Bank* v. *Nelson*, 517 U.S. 25, 27-28 (1996) (emphasis omitted). Because permitting respondents to seek treble damages under RICO neither precludes Nevada from enforcing its insurance laws nor impedes petitioners from obeying them, RICO's treble damages remedy does not pre-empt state law and does not "invalidate, impair, or supersede" it within the meaning of Section 2(b).

B. Petitioners' effort to construe the terms "invalidate, impair, or supersede" more broadly is inconsistent with the statutory text. In essence, they argue that providing a greater remedy under RICO "impairs" or "supersedes" state law by "'upset[ting] the balance' of regulation * * * that the states have carefully constructed." Alliance of Am. Insurers Br. at 26; see Pet. Br. 22-23. But Section 2(b) bars federal statutes from being construed to "invalidate, impair, or supersede" not merely laws "enacted * * * for the purpose of regulating the business of insurance," but also "any law * * * which imposes a fee or tax upon such business." 15 U.S.C. 1012(b). If federal law were to "invalidate, impair, or supersede" state insurance regulation merely because it imposes additional or greater liability for misconduct than does state law, then federal law presumably would also "invalidate, impair, or supersede" state insurance "fee[s] or tax[es]" within the meaning of Section 2(b) whenever it imposes additional or greater tax liability than does the State. Generally applicable federal fees and taxes, however, do not "invalidate, impair, or supersede" state insurance taxes and fees within the meaning of Section 2(b) where nothing precludes insurers from paying both. For the same reason, generally applicable federal sanctions for criminal misconduct, like those provided under RICO, do not "invalidate, impair, or supersede" state insurance law within the meaning of Section 2(b) if insurers can comply with both.

In addition, petitioners' construction effectively would make state insurance law pre-empt the field of remedies for conduct that violates both state and federal law. But Congress knew how to give state law such a pre-emptive effect, and chose not to do so with respect to statutes such as RICO. Under the second sentence of Section 2(b), the Sherman Act and other specifically-identified statutes are "applicable to the business of insurance" only "*to the extent that* such business *is not regulated* by State Law." 15 U.S.C. 1012(b) (emphasis added). Congress did not make state law pre-empt the field with respect to statutes that, like RICO, were not specifically listed in the second sentence of Section 2(b).

C. The ordinary and sensible presumption is that a federal law of general applicability such as RICO applies uniformly to all persons whose conduct falls within the statutory proscription. The rule of statutory construction prescribed by the McCarran-Ferguson Act should not be distorted to create disuniformities in the application of other Acts of Congress absent a showing that the particular disuniformity is required to prevent a state insurance law from actually being "invalidat[ed], impair[ed], or supersede[d]." No such showing can be made here. Indeed, such a showing could not be made even under an unduly expansive interpretation of those terms. Nevada state law permits private actions for fraud and deceit in the insurance context, and permits recovery of punitive damages that may well exceed the amount that could be recovered under RICO. Since private actions in Nevada's own courts co-exist with its system of insurance regulation, there is no reason why RICO actions in federal courts cannot co-exist with that system as well.

ARGUMENT

THE McCARRAN-FERGUSON ACT DOES NOT PRECLUDE INJURED PERSONS FROM SEEKING A FEDERAL REMEDY FOR A PATTERN OF CRIMINAL MAIL FRAUD PERPETRATED BY A MEDICAL INSURER

"[T]he starting point in a case involving construction of the McCarran-Ferguson Act, like the starting point in any case involving the meaning of a statute, is the language of the statute itself." *Department of Treasury* v. *Fabe*, 508 U.S. 491, 500 (1993). The meaning of a statute, however, is not discerned by examining "a single sentence or member of a sentence" in isolation, but rather by "look[ing] to the provisions of the whole law, and to its object and policy." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 51 (1987) (internal quotation marks omitted); see *McCarthy* v. *Bronson*, 500 U.S. 136, 139 (1991) ("[S]tatutory language must always be read in its proper context.").

Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b), provides in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

Because RICO does not "specifically relat[e] to the business of insurance," the issue in this case is the meaning of the phrase "invalidate, impair, or supersede [state] law."

Relying on dictionary definitions, petitioners would give the terms "invalidate," "impair," and "supersede" a broad construction so as to bar federal remedies that have some (unspecified) modicum of effect on the business of insurance. But petitioners make no effort to determine the legal source from which the terms "invalidate, impair, or supersede" in Section 2(b) were drawn. Nor do they examine how those

terms were used and understood by lawmakers and the courts when the McCarran-Ferguson Act was enacted. As a result, they overlook the most natural understanding of the phrase "to invalidate, impair, or supersede [state] law"—that it means, in modern parlance, "to pre-empt state law."

Thus, the McCarran-Ferguson Act does not declare that federal statutes shall not be construed as affecting the business of insurance or its regulation. Instead, it declares that general federal statutes should not be construed as *pre-empting* state insurance laws. As this Court has explained, Section 2(b) is "a special federal anti-pre-emption rule, which provides that a federal statute will *not* pre-empt a state statute enacted 'for the purpose of regulating the business of insurance'—unless the federal statute 'specifically relates to the business of insurance.'" *Barnett Bank* v. *Nelson*, 517 U.S. 25, 27-28 (1996) (emphasis omitted). Because permitting respondents to pursue the federal remedies provided under RICO would not pre-empt Nevada's insurance laws—Nevada remains free to enforce state law norms, and nothing precludes petitioners from obeying them—RICO does not "invalidate, impair, or supersede" state insurance law within the meaning of Section 2(b).

A. Federal Law Invalidates, Impairs, or Supersedes State Law Only If It Pre-Empts State Law

1. Congress enacted the McCarran-Ferguson Act in response to this Court's decision in *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), which held that the issuance of insurance is interstate commerce and that, as a result, the practices of insurers are subject to scrutiny under federal legislation, including the Sherman Act. 322 U.S. at 539-561; see pp. 1-2, *supra*. The "decision provoked widespread concern that the States would no longer be able to engage in taxation and effective regulation of the insurance industry." *St. Paul Fire & Marine*, 438 U.S. at 539. As the dissenting opinions in *South-Eastern Under-*

writers noted, under the Court's holding, the Sherman Act would pre-empt the insurance laws of several States: The "statutes of at least five states will be invalidated by the decision as in conflict with the Sherman Act," Chief Justice Stone explained, "and the argument in this Court reveals serious doubt whether many others may not also be inconsistent with that Act." 322 U.S. at 581 (dissenting opinion). Moreover, according to the dissenting opinions, the *South-Eastern Underwriters* decision might have made the Court's dormant Commerce Clause cases applicable to the subject of insurance, thereby precluding state taxation and regulation altogether. See *ibid.* (Stone, C.J., dissenting) ("The extent to which still other state statutes will now be invalidated as in conflict with the commerce clause has not been explored."); see also *id.* at 586-587 (Jackson, J., dissenting) (warning that Commerce Clause has effect of "restricting state power").

Congress responded with the McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq.*, which declares that no federal statute "shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance" unless the federal statute specifically relates to insurance. 15 U.S.C. 1012(b). Congress, however, did not choose the words "invalidate, impair, or supersede" at random. Those words had a familiar usage in this Court's decisions, and they were so utilized in the dissenting opinions in *South-Eastern Underwriters* in particular. Those opinions did not use the terms "invalidate," "impair," and "supersede" to describe mere indirect effects on state law, or the proclivity of litigants to rely on federal rather than state remedies. Instead, they used those terms to mean, in modern parlance, "pre-empt."

Indeed, the term "invalidate" apparently was drawn from Chief Justice Stone's dissent, which warned that many state statutes "will be *invalidated* by the [*South-Eastern Underwriters*] decision as in conflict with the Sherman Act." 322 U.S. at 581 (emphasis added); see also *id.* at 562 (opinion of

the Court) (rejecting as "exaggerated" the "argument that the Sherman Act necessarily invalidates many state laws"). And the terms "impair" and "supersede" appear to have been drawn from Justice Jackson's dissenting opinion, which likewise used them to mean "pre-empt." Under the Supremacy Clause, Justice Jackson explained, Congress's exercise of its Commerce Clause powers "*impairs* state regulation only in so far as it actually conflicts with the federal regulation." 322 U.S. at 587 (emphasis added); see also *ibid.* (urging an alternative rationale that "would leave the basis of state regulation unimpaired"). And, Justice Jackson further warned, "if the present trend" toward increasing the scope of what constitutes interstate commerce—over which "congressional power to regulate prevails over that of the states"—continues, "federal regulation eventually will *supersede* that of the states." *Id.* at 586 (emphasis added).

The dissenting opinions' use of the terms "invalidate, impair, or supersede" to mean "pre-empt" was consistent with then-prevailing legal usage. When the McCarran-Ferguson Act was passed, the word "invalidate" meant (as it does today) to "render of no force or effect." *Webster's New International Dictionary* 1135 (1917). Consistent with that definition, this Court regularly used the phrase "invalidate * * * law" to describe pre-emption, declaring that, if a state law is in irreconcilable conflict with or repugnant to federal law (whether statutory or constitutional), it is "invalid" or "invalidated" thereby. See, *e.g.*, *Hines* v. *Davidowitz*, 312 U.S. 52, 69 n.23 (1941) ("In the only case of this type in which there was an outstanding treaty provision in conflict with the state law, this Court held the state law invalid."); *Todok* v. *Union State Bank*, 281 U.S. 449, 456 (1930) ("[T]he treaty did not invalidate the provisions of the Nebraska statute."); *Carpenters & Joiners Union* v. *Ritter's Café*, 315 U.S. 722, 734 (1942) (Reed, J., dissenting) ("legislation forbidding picketing * * * was invalidated" as "unconstitutional"); *Carter* v. *Virginia*, 321 U.S. 131, 139 (1944) (Black, J., concurring)

("This Court could invalidate the Virginia regulations, but only the Congress could devise and substitute effective regulations to take their place.").[3] Petitioners concede that the term "invalidate" is best read as meaning "pre-empt." Pet. Br. 20 (the term "invalidate" can "be equated with 'preempt' and limited to * * * conflict between state and federal law").

Likewise, while the term "impair" by itself generally means "to diminish in quantity, value, excellence, or strength," *Webster's*, *supra*, at 1077, "or otherwise affect in an injurious manner," *Black's Law Dictionary* 921 (3d ed. 1933), the phrase to "impair [a] law" long has been uniquely associated with conflict pre-emption. The phrase connotes partial pre-emption, *i.e.*, the displacement of some portion of a statute or its preclusion in certain contexts. Justice Jackson used the phrase precisely in that manner in his *South-Eastern Underwriters* dissent: When Congress exercises its Commerce Clause powers, he explained, "it impairs state regulation only in so far as it actually conflicts with the federal regulation." 322 U.S. at 587. And, at the time the McCarran-Ferguson Act was passed, this Court used the phrase "impair * * * law" in that sense as well. See, *e.g.*, *United States* v. *Waddill, Holland & Flinn, Inc.*, 323 U.S. 353, 357 (1945) (state construction of local law "cannot operate by itself to impair or supersede a long-standing Congressional declaration of priority" for certain types of claims); *Henry Ford & Son, Inc.* v. *Little Falls Fibre Co.*, 280 U.S. 369, 378 (1930) ("[T]he powers conferred by [the statute] on the Commission do not extend to the impairment of the operation of those laws or to the extinguishment of rights acquired under them."); *Guaranty Trust Co.* v. *United States*, 304 U.S. 126, 143 (1938) ("Even the language of a treaty wherever reasonably possible will be construed so as

[3] See also *Parker* v. *Brown*, 317 U.S. 341, 361 (1943); *Gwin, White & Prince, Inc.* v. *Henneford*, 305 U.S. 434, 446 (1939) (Black, J., dissenting).

not to override state laws or to impair rights arising under them.").[4] Indeed, at least one pre-McCarran-Ferguson Act statute used the phrase "impair * * * law" to convey precisely that meaning, and this Court interpreted the statute as declaring that federal law should not pre-empt state regulation. *Rice* v. *Board of Trade*, 331 U.S. 247, 255 (1947) (section providing that federal statute shall not "be construed to impair any [applicable] State law" shows that "Congress did not preclude state regulation," and "serves the function of preventing supersedure * * * where state and federal law overlap"); see also *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 101-102 (1983) ("pre-emption" of cause of action and forum through which federal rights are enforced "impair[s]" or "modif[ies]" federal law).[5]

[4] See also *New York, N.H. & H.R.R.* v. *State of New York*, 165 U.S. 628, 631 (1897) ("[T]he mere grant to congress of the power to regulate commerce with foreign nations and among the states did not * * * impair the authority of the states to establish * * * regulations."); *Peck* v. *Jenness*, 48 U.S. 612, 614 (1849) (state law liens "not to be annulled, destroyed, or impaired under the proceedings in bankruptcy"); *Corfield* v. *Coryell*, 6 F. Cas. 546 (E.D. Pa. 1823) (No. 3230) (Congress's power over interstate commerce does not "impair the right of the state governments to legislate.").

[5] With respect to laws, "impair" also has been used to mean to "conflict" sufficiently as to warrant pre-emption under the Supremacy Clause. See *Parker* v. *Brown*, 317 U.S. 341, 368 (1943) (state regulation valid because it "does not impair national control over the commerce in a manner or to a degree forbidden by the Constitution"); *Stone* v. *Interstate Natural Gas Co.*, 103 F.2d 544, 550 (5th Cir. 1939). As demonstrated above, however, Congress used the word "impair" in the McCarran-Ferguson Act in the same sense that Justice Jackson used it in *South-Eastern Underwriters*, *i.e.*, to mean "pre-empt" in part. See also n.12, *infra*. In any event, even if Congress used the term "impair" to mean "conflict" in such a manner as to warrant pre-emption, it would not alter the conclusion that federal law "invalidate[s], impair[s], or supersede[s]" state insurance law within the meaning of Section 2(b) only if the two directly conflict. See *Northwest Cent. Pipeline Corp.* v. *State Corp. Comm'n*, 489 U.S. 493, 509 (1989) (State law "conflicts with federal law" where "it is impossible to comply with both" or "state law stands as an obstacle to the accomplishment and execution of congressional objec-

The term "supersede" has a similar pedigree. In accordance with its accepted definition—to "displace, or set aside, and put another in place of; to supplant," *Webster's*, *supra*, at 2082—this Court consistently used the term "supersede" in the context of state-federal relations to mean "pre-empt," particularly where federal law not only bars reliance on state law, but also provides a federal rule to operate in its place. See, *e.g.*, *Illinois Commerce Comm'n* v. *Thomson*, 318 U.S. 675, 682 (1943) ("[T]he Interstate Commerce Commission * * * has power to supersede an intrastate rate by prescribing in its stead a new rate."); *Midstate Horticultural Co.* v. *Pennsylvania R.R.*, 320 U.S. 356, 359 (1943) ("Respondent however insists the Act has not superseded, but has merely modified its common law contractual right."); *Allen-Bradley Local No. 1111* v. *Wisconsin Employment Relations Bd.*, 315 U.S. 740, 749 (1942) (as the "federal system of alien registration" already had been "held to supersede a state system of registration," the Court is "more ready to conclude that a federal act in a field that touched international relations superseded state regulation than * * * where a State [regulates] local matters"); *J.I. Case Co.* v. *NLRB*, 321 U.S. 332, 338 (1944) ("The very purpose of providing by statute for the collective agreement is to supersede the terms of separate agreements of employees."); *Davies Warehouse Co.* v. *Bowles*, 321 U.S. 144, 152 (1944) ("[W]e think Congress did not intend * * * to supersede the power of a state regulatory commission, exercising comprehensive control."); *District of Columbia* v. *Pace*, 320 U.S. 698, 703 (1944) ("This general rule * * * would hardly supersede a special statutory measure.").[6]

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tives."); *N.A.A.C.P.* v. *American Family Mut. Ins. Co.*, 978 F.2d 287, 295-297 (7th Cir. 1992), cert. denied, 508 U.S. 907 (1993).

[6] Petitioners are incorrect to assert (Pet. Br. 17) that so construing Section 2(b) renders the terms "impair" and "supersede" mere surplusage. To the contrary, each word in the phrase "invalidate, impair, or supersede" has a slightly different connotation, and only collectively do they encompass the concept of pre-emption. The term "invalidate" means to render ineffective, generally without providing a replacement rule or law. See *Carter*, 321 U.S. at 139 (Black, J., concurring) ("This Court could invalidate the Virginia regulations, but only the Congress could devise and substitute effective regulations to take their place."). The term "supersede" means to displace (and thus render ineffective) while providing a substitute rule. See *Webster's*, *supra*, at 2082; *Illinois Commerce Comm'n*, 318 U.S. at 682 (The ICC "has power to supersede an intrastate rate by prescribing in its stead a new rate."). And the term "impair" is associated with partial pre-emption that displaces a state scheme only in certain contexts or respects. See 322 U.S. at 587 (Jackson, J., dissenting) (federal statute "impairs state regulation only in so far as it actually conflicts with the federal regulation"). In any event, to the extent the meanings of the terms overlap, the rule that each word must be construed to have meaning and effect does not apply to instances of lawyerly iteration. See *Moskal* v. *United States*, 498 U.S. 103, 120 (1990) (Scalia, J., dissenting) ("Nor should [the superfluity principle] be applied to the obvious instances of iteration to which lawyers, alas, are particularly addicted.").

Because the *South-Eastern Underwriters* dissents used the terms "invalidate," "impair" and "supersede" law to convey the notion of pre-emption—and because that was the prevailing legal usage at the time—it is most natural to read the McCarran-Ferguson Act (which was specifically addressed to that decision) as using those terms in the same sense. Where Congress borrows legal terms from a particular source, it borrows their meaning as well. *United States* v. *Turley*, 352 U.S. 407, 411 (1957) (common-law terms construed consistent with their common-law meaning); *Moskal* v. *United States*, 498 U.S. 103, 121 (1990) (Scalia, J., dissenting) ("[W]hen a statute employs a term with a specialized legal meaning relevant to the matter at hand, that meaning governs. * * * [A]s Justice Frankfurter more poetically put it: '[I]f a word is obviously transplanted from another legal source * * * it brings its soil with it.'"); see also *United States* v. *Wells*, 519 U.S. 482 (1997).[7]

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[7] It is not significant that Congress did not use the term "pre-empt." That term did not in 1945 have its current breadth of meaning or widespread use; none of the opinions in *South-Eastern Underwriters* used it. Our research indicates that "pre-empt" was not used in this Court's cases to mean displacement of state law until 1917, when Justice Brandeis used

Thus, as this Court has recognized, Section 2(b) is "a special federal anti-pre-emption rule, which provides that a federal statute will not pre-empt a state statute enacted 'for the purpose of regulating the business of insurance'—unless the federal statute 'specifically relates to the business of insurance.'" *Barnett Bank*, 517 U.S. at 27-28 (emphasis omitted); see *id.* at 30 (referring to "the McCarran-Ferguson Act's special anti-pre-emption rule"); *Fabe*, 508 U.S. at 496-497 (referring to 15 U.S.C. 1012 as "the anti-pre-emption provisions of the McCarran-Ferguson Act"); *Fabe*, 508 U.S. at 515 (Kennedy, J., dissenting) ("The first clause of §1012(b) * * * provides that state laws enacted for the purpose of regulating the business of insurance are saved from pre-emption."); *id.* at 510 (Kennedy, J., dissenting) ("[T]he McCarran-Ferguson Act * * * provides an exemption from pre-emption for certain state laws."). That is also precisely how Senator Ferguson—whose name the Act bears—characterized Section 2(b). The Act, Senator Ferguson explained, "provides that no Federal legislation relating to interstate commerce shall by implication *repeal* any existing State law unless such act of Congress specifically so provides." 91 Cong. Rec. 483 (1945) (emphasis added).[8]

2. The express declaration of purpose contained in Section 1 of the McCarran-Ferguson Act, 15 U.S.C. 1011, confirms that Section 2(b) is best read as an anti-pre-emption provision that prevents "repeal" of state insurance laws. Section 1 of the Act does not say that Congress seeks to avoid having any effect on the insurance business. Instead, it declares that the States should not be foreclosed from imposing their own regulations: "[T]he continued regulation and taxation by the several States of the business of insurance is in the public interest." 15 U.S.C. 1011. And it asserts that federal enactments should not be read as precluding the States from doing so, absent an expressed intent to the contrary: "[S]ilence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. 1011. Nothing in the Act's declaration of purpose evidences an intent to deprive federal law of its usual force and effect where federal law does not "prevent continued state regulation" and state and federal law can co-exist.

The Act's historical origin and purpose point in the same direction. The McCarran-Ferguson Act was designed to address the specific concerns that arose from the *South-*

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the phrase "pre-empt[] the whole field" in dissent in *New York Central R.R.* v. *Winfield*, 244 U.S. 147, 169; the majority, however, used the word "supersede," *id.* at 148 ("[S]tate laws covering the same field are necessarily superseded."). The term pre-empt appears occasionally in cases from the late 1930s and early 1940s, but appears confined to the concept of "field pre-emption." See, *e.g.*, *Puerto Rico* v. *Shell Co.*, 302 U.S. 253, 260 (1937) ("act of Congress" had not "preëmpted the ground occupied by the local act and superseded it"); *Faitoute Co.* v. *Asbury Park*, 316 U.S. 502, 507 (1942) (rejecting argument that a particular "field of lawmaking has been preempted"); *Rice* v. *Santa Fe Elevator Corp.*, 331 U.S. 218, 237 (1947) (Congress had not moved "into these fields" and "pre-empted" them). We have found no indication that the Court began using the word "pre-empt" to describe what we now call conflict pre-emption and express pre-emption until the mid 1950s, see, *e.g.*, *Weber* v. *Anheuser-Busch, Inc.*, 348 U.S. 468, 480 (1955) (although the "areas that have been pre-empted * * * are not" easily delineated, "[o]bvious conflict, actual or potential, leads to easy judicial exclusion of state action"); *San Diego Unions* v. *Garmon*, 359 U.S. 236, 240 (1959) (similar), or the specific labels "express pre-emption" and "conflict pre-emption" until 1973 and 1989, see *City of Burbank* v. *Lockheed Air Terminal*, 411 U.S. 624, 636 (1973) ("express pre-emption section"); *Northwest Cent. Pipeline* v. *State Corp. Comm'n*, 489 U.S. 493, 515 (1989) ("conflict pre-emption analysis").

[8] That is how Senator Ferguson's colleagues understood the provision as well. 91 Cong. Rec. 485 (1945) (describing the bill as declaring that "No act of Congress shall ever presume to invalidate a State law on the subject of insurance") (Sen. Taft); *id.* at 486 ("The section before us provides that no act of Congress shall be construed to invalidate a State law unless the act of Congress specifically states that the State law is in conflict with the Federal act and is designed to override it.") (Sen. Revercomb); *id.* at 1090 ("The methods of control exercised by the States and by the Federal Government are conflicting, and the sole purpose of this bill is to take out as much of that conflict as possible.") (Rep. Gwynne).

Eastern Underwriters decision. *St. Paul Fire & Marine*, 438 U.S. at 538; *Fabe*, 508 U.S. at 499. That decision was considered problematic not because federal law might impose *additional* duties—or taxes or burdens—supplementing state law. Rather, many feared that federal law, and the Commerce Clause, might be read to *supplant* or *pre-empt* state taxation and regulation, as evidenced by the *South-Eastern Underwriters* dissents, see pp. 11-13, *supra*, and the petitions for rehearing filed by the defendants and the States.[9] By declaring that federal law will not be construed as pre-empting state law, Section 2(b) responds directly to those concerns, "remov[ing] [the] obstructions [to continued state regulation and taxation] which might be thought to flow from [Congress's] own power, whether dormant or exercised, except as otherwise expressly provided." *Prudential Ins. Co.* v. *Benjamin*, 328 U.S. 408, 429-430 (1946); see *Wilburn Boat Co.* v. *Fireman's Fund Ins. Co.*, 348 U.S. 310, 319 (1955) ("[T]he McCarran Act * * * was designed to assure that existing state power to regulate insurance would continue."); *FTC* v. *Traveler's Health Ass'n*, 362 U.S. 293, 299 (1960) (similar). Indeed, given that each provision in the McCarran-Ferguson Act is framed as a response to concerns raised by the *South-Eastern Underwriters* dissents,[10] it

[9] Petition for Rehearing at 7, *South-Eastern Underwriters*, *supra* ("[T]he effect of the decision is not only to call into question state statutes which are inconsistent with the Sherman Act, but also to place all existing state regulation of insurance in jeopardy."); Petition of the State of New York in Support of Motion for Rehearing at 1 ("This Court's decision that insurance is commerce creates problems without foreseeable limit concerning the effect of Federal statutes and concerning the extent to which State regulations are now permissible.").

[10] In response to the concern that the Commerce Clause might be read as precluding state regulation of insurance entirely, see pp. 2, 12, *supra*, Section 2(a) of the Act delegates the national power over interstate insurance to the States. 15 U.S.C. 1012(a). To address the immediate effect of the antitrust laws (and other specifically identified statutes) on state law, see 322 U.S. at 581 (Stone, C.J., dissenting); pp. 2, 12-13, *supra*, Congress declared a partial moratorium on their application to the business of insurance for four years, and limited their applicability thereafter. See p. 3, *supra*; 15 U.S.C. 1013(a) and (b); 15 U.S.C. 1012(b). Finally, to address the possibility that state law might be pre-empted by other, unidentified, federal statutes, see n.9, *supra*, Congress declared that no federal statute should be read to pre-empt—or, in the language of those times, to "invalidate, impair, or supersede"—state insurance law absent a clear indication that Congress so intended. 15 U.S.C. 1012(b).

would be implausible to conclude that the Act sought to rectify an alleged problem—the creation of supplementary federal remedies rather than pre-emptive laws—that neither the Members of this Court nor the litigants identified.

3. Because Section 2(b) effectively deprives many federal laws of potentially pre-emptive effect on state insurance law, it forecloses most arguments that state law is precluded by federal norms. It also forecloses application of federal law (not addressed to insurance) that would irreconcilably conflict with state law, *i.e.*, that would necessarily have the effect of "pre-empting" or "repealing" state insurance law. Thus, in *Fabe*, 508 U.S. at 502, this Court found "a direct conflict between [federal law] and [state] law" where the two provided different priority rules for the distribution of insurer assets, and applying one rule would necessarily preclude the other. As the Court observed:

> Ordinarily, a federal law supersedes any inconsistent state law. The first clause of § 2(b) reverses this by imposing what is, in effect, a clear-statement rule, a rule that state laws enacted 'for the purpose of regulating the business of insurance' do not yield to *conflicting* federal statutes unless a federal statute specifically requires otherwise.

Id. at 507 (emphasis added); see also *Barnett Bank*, 517 U.S. at 42 (where general "federal statutes with potentially pre-emptive effect * * * *conflict* with state [insurance] law" then "the McCarran-Ferguson Act's anti-pre-emption rule will apply") (emphasis added).

Consequently, the First, Fifth, Seventh, and Ninth Circuits were correct to conclude that, absent a direct conflict between state and federal law—such that federal law would not supplement but rather would "pre-empt" or "repeal" state insurance law—applying federal law to insurance-related conduct does not "invalidate, impair, or supersede" state law within the meaning of the Act. See *Villafane-Neriz* v. *FDIC*, 75 F.3d 727, 736 (1st Cir. 1996); *United States* v. *Cavin*, 39 F.3d 1299, 1305 (5th Cir. 1994); *N.A.A.C.P.* v. *American Family Mut. Ins. Co.*, 978 F.2d 287, 295 (7th Cir. 1992), cert. denied, 508 U.S. 907 (1993); *Merchants Home Delivery Serv., Inc.* v. *Frank B. Hall & Co.*, 50 F.3d 1486, 1491-1492 (9th Cir. 1995), cert. denied, 516 U.S. 964 (1995); see also *Sabo* v. *Metropolitan Life Ins. Co.*, 137 F.3d 185, 193 (3d Cir. 1998) (First, Seventh and Ninth Circuits "look[] to a direct conflict in the substantive provisions of the federal and state statutes at issue"), petition for cert. pending, No. 98-2. Simply put, if federal law neither precludes application of state insurance law nor impedes compliance therewith, it neither pre-empts state law nor "invalidate[s], impair[s], or supersede[s]" that law within the meaning of Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. 1012(b).

4. Judged by these standards, it is clear that permitting the victims of a pattern of criminal mail fraud to pursue a treble damages remedy under RICO does not "invalidate, impair, or supersede" Nevada insurance law. Petitioners do not allege that RICO prohibits conduct that Nevada law compels. Nor do they identify a Nevada law that will be rendered unenforceable in whole or in part. To the contrary, they concede (as they must) that Nevada law bars the conduct at issue in this case just as surely as federal law. Because the dictates of federal and state law do not conflict, and because nothing precludes petitioners from complying with both, Section 2(b) does not bar respondents from seeking a treble damages remedy under federal law. As Judge Easterbrook observed, anyone asserting that the McCarran-Ferguson Act precludes reliance on federal law "needs to show that the [federal law] conflicts with state law. Duplication is not conflict." *American Family*, 978 F.2d at 295.

For similar reasons, this case cannot be meaningfully distinguished from *SEC* v. *National Securities, Inc.*, 393 U.S. 453 (1969). There, the Securities and Exchange Commission sought to bar, under the federal securities laws, the merger of two insurance companies even though state insurance regulators had approved it. The question before the Court there, as here, was "whether the McCarran-Ferguson Act bars a federal remedy which affects a matter subject to state insurance regulation." 393 U.S. at 462. Although respondent there argued "that any attempt to interfere with a merger approved by state insurance officials would 'invalidate, impair, or supersede' the state insurance laws," the Court rejected that argument:

> Arizona has not commanded something which the Federal Government seeks to prohibit. It has permitted respondents to consummate the merger; it did not order them to do so. * * * The paramount federal interest in protecting shareholders is in this situation perfectly compatible with the paramount state interest in protecting policyholders. * * * In these circumstances, we simply cannot see the conflict."

Id. at 463. The same reasoning applies here with even greater force. If applying federal law to bar a transaction *approved* by state law does not "invalidate, impair, or supersede" state law within the meaning of the Act, it follows *a fortiori* that providing a federal remedy for conduct that is similarly *prohibited* by state law does not either.

B. Petitioners' Construction Of Section 2(b) Is Inconsistent With The Statutory Text, Structure, And Purpose

1. Ignoring the fact that Section 2(b) is most naturally read as a "special anti-pre-emption provision," *Barnett*

Bank, 517 U.S. at 27; *Fabe*, 508 U.S. at 496-497, petitioners and their amici argue that Section 2(b) precludes private parties from relying on federal remedies that have a non-"trivial" effect on the business of insurance or its regulation. Pet. Br. 24. Congress, they assert, "intended to withdraw * * * from the field absent an express congressional statement to the contrary." Pet. Br. 10; see Alliance of Am. Insurers Br. at 12-13, 14-15; Consumer Credit Ins. Ass'n Br. at 7-9. That argument, however, is contrary to statutory text. The Act does not declare that "No Act of Congress shall apply to the business of insurance unless such Act specifically relates thereto." It declares that general federal statutes shall not be construed to "invalidate, impair, or supersede" state insurance laws. 15 U.S.C. 1012(b).[11]

Petitioners accordingly attempt to give the terms "invalidate, impair, or supersede" an over-broad construction. While conceding that the term "invalidate" can "be equated with 'pre-empt' and limited to * * * conflict[s] between state and federal law," Pet. Br. 20, petitioners rely on dictionary definitions to argue that the words "impair" and "supersede" can be read more broadly, *id.* at 20-21. But Congress did not randomly pluck the terms "impair" and "supersede" from the pages of a dictionary. It used those terms in light of their specific connotation, as reflected in this Court's cases and the *South-Eastern Underwriters* dissents. See pp. 12-17, *supra*. Those sources show that to "supersede" or to "impair," when used in the phrase to "impair [state] law" or to "supersede [state] law," means to "pre-empt." *Ibid.* Any other construction would be at odds with the Act's express purpose and historical context. See pp. 19-21, *supra*.[12]

[11] The floor statement of Representative Gwynne on which petitioners repeatedly rely for the proposition that Congress sought to remove itself from the field entirely, Pet. Br. 14 n.9, 18 n.10, cannot be reconciled with Section 2(b)'s text. Indeed, Representative Gwynne himself recognized that Section 2(b) did not render federal law inoperative as a general matter, but rather did so *only* in cases of conflict. 91 Cong. Rec. 1090 (1945) ("The methods of control exercised by the States and by the Federal Government are conflicting, and the sole purpose of this bill is to take out as much of that conflict as possible."). Besides, it is settled law that the McCarran-Ferguson Act did not return the law to its pre-*South-Eastern Underwriters* state. *Fabe*, 508 U.S. at 507; *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 220 (1979).

2. Petitioners' over-broad theory of "impairment" and "supersession" conflicts with the Act's text in two additional ways. Following the reasoning of the Sixth and Eighth Circuits (rather than that of the First, Fifth, Seventh, and Ninth), petitioners and their amici argue that providing a greater remedy under RICO than under state law "impairs" or "supersedes" state law by "'upset[ting] the balance' of regulation * * * that the states have carefully constructed." Alliance of Am. Insurers Br. at 26; see Pet. Br. 22-23; *Doe* v. *Norwest Bank Minnesota, N.A.*, 107 F.3d 1297, 1306-1307 (8th Cir. 1997); *Kenty* v. *Bank One, Columbus, N.A.*, 92 F.3d 384, 392 (6th Cir. 1996). In essence, they argue, state law should be viewed as pre-empting the field of remedies for insurance-related fraud. See Pet. Br. 23-24 (relying on analogy to *Garmon* pre-emption); Alliance of Am. Insurers Br. at 27-28.

Congress knew how to give state law such a broad pre-emptive effect, and expressly did so with respect to the Sherman Act and certain other specifically-listed federal statutes, but did not do so with respect to unlisted statutes such as RICO. See pp. 3, 9, *supra*; see also *FTC* v. *National*

[12] Even if "impair * * * law" could be given a more expansive meaning than pre-empt, the fact that "invalidate" and "supersede" so clearly connote pre-emption make it appropriate to interpret "impair" in that sense as well. "The traditional canon of construction, *noscitur a sociis*, dictates that words grouped in a list should be given a related meaning." *Dole* v. *United Steelworkers*, 494 U.S. 26, 35 (1989) (internal quotation marks omitted)). In any event, the most plausible alternative legal meaning for the phrase to "impair * * * law" is to affect in such an injurious manner as to warrant pre-emption under the doctrine of conflict pre-emption. See n.5, *supra*. That construction would lead to the same result we urge here. *Ibid.*

Cas. Co., 357 U.S. 560, 564 (1958). Nor did Congress declare that federal law in general should be inapplicable whenever the States have regulated. Those omissions are presumed to be deliberate, see *Gozlon-Peretz* v. *United States*, 498 U.S. 395, 404 (1991), and in fact were, see 91 Cong. Rec. 486-488 (1945). Consequently, those seeking to avoid the application of federal law generally cannot argue simply that the State has regulated the field. Instead, as the Fourth Circuit has explained, they must "point[] to a law enacted by [the State] which would be 'impaired,'" invalidated, or superseded. "The presence of a general regulatory scheme does not show that any particular state law would be invalidated, impaired, or superseded." *Mackey* v. *Nationwide Ins. Co.*, 724 F.2d 419, 421 (4th Cir. 1984).

Moreover, Section 2(b) bars federal statutes from being construed to "invalidate, impair, or supersede" not only "any law enacted * * * for the purpose of regulating the business of insurance," but also "any law * * * which imposes a fee or tax upon such business." 15 U.S.C. 1012(b). If federal law were to "invalidate, impair, or supersede" state insurance regulation merely because it imposes additional or greater liability for misconduct than does state law, then federal law presumably also would "invalidate, impair, or supersede" state insurance "fee[s] or tax[es]" within the meaning of Section 2(b) whenever it imposes additional fees or greater tax liability than does the State. Generally applicable federal taxes and fees may alter the amount that States can collect from insurers; and no less than statutory liability for misconduct, they may "upset the balance" of tax or fee burdens imposed on insurers by state law. But, under our established federal system of dual taxation, generally applicable federal fees and taxes do not "invalidate, impair, or supersede" state insurance taxes and fees within the meaning of Section 2(b) where nothing precludes insurers from paying both. For the same reason, generally applicable federal sanctions for criminal misconduct, like those provided under RICO, do not "invalidate, impair, or supersede" state insurance regulations within the meaning of Section 2(b) so long as insurers can comply with both. See *Ratzlaff* v. *United States*, 510 U.S. 135, 143 (1994) (single phrase in statute cannot be given two different meanings); *Cohen* v. *De La Cruz*, 118 S. Ct. 1212, 1217 (1998) ("[E]quivalent words have equivalent meaning when repeated in the same statute.").

3. Finally, the construction of "impairs" and "supersedes" proposed by petitioners and their amici is undermined by its vagueness. Under petitioners' construction, federal courts—rather than asking whether federal law would effectively pre-empt or repeal a state statute—must engage in indeterminate speculation about the effect federal remedies might have on a "balance" of policies inferred from an overall state scheme. It is difficult to judge what effects, if any, federal law has on state regulation; it is not possible to articulate an objective test to determine when the effects would be sufficient (or, as petitioners put it (Br. at 24), non-"trivial" enough) to warrant displacement of federal law; and inferring the policies underlying state law—or the intent of the state legislature with respect to pre-emption—is hazardous at best.[13] Petitioners here thus ask the Court to draw the dubious inference that, because Nevada did not provide for treble damages under its own insurance laws, permitting such a recovery under federal law would offend an unarticulated state policy.[14] It is highly unlikely that Congress would

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[13] Thus, the Sixth Circuit has decided that permitting jury trials, attorney's fees awards, and punitive damages awards under the Fair Housing Act does not impair Ohio insurance law, *Nationwide Mut. Ins. Co.* v. *Cisneros*, 52 F.3d 1351 (1995), cert. denied, 516 U.S. 1140 (1996), but that RICO's treble damages and attorney's fees provision does, *Kenty*, 92 F.3d at 392. In doing so, it has not articulated a legal standard that could not be utilized to reach the opposite conclusions.

[14] To the extent petitioners or their amici rely on the preamble to Nevada's insurance laws, see, *e.g.*, Consumer Credit Ins. Ass'n Br. at 10, their submission is unpersuasive. The preamble is addressed to the pro-

have directed federal courts to embark on such a perilous undertaking without offering any guidance. In any event, the Act does not ask courts to look at state policy; it requires them to determine whether applying a federal statute would "invalidate, impair, or supersede any [state] *law*." 15 U.S.C. 1012(b) (emphasis added). Because petitioners cannot identify a Nevada *law* that would suffer such a fate, permitting respondents to seek treble damages under RICO does not offend the rule of construction provided by Section 2(b).

C. RICO Does Not Invalidate, Impair, or Supersede Nevada Insurance Law Under Any Construction Of Those Terms

Even if to "impair" or "supersede" a law were incorrectly construed to mean "undermine" to some (unspecified) degree, or to render "unnecessary" or "superfluous," RICO does not have such an effect.

1. Contrary to the protestations of petitioners and their amici, Pet. Br. 20-21; Consumer Credit Ass'n Br. at 12-13, RICO does not supersede state law by rendering it "superfluous." Even if respondents may proceed under RICO, Nevada officials will continue to regulate the insurance industry under their own system of law, not based on federal norms. Likewise, the victims of insurance fraud will not abandon state remedies in favor of federal law. RICO reaches only a small subset of the conduct covered by state insurance laws; its greater remedies may be invoked only in exceptional cases where the elements of a RICO violation can be proved—cases in which the defendant has not merely committed a tort or regulatory violation, but has demonstrated extreme culpability by conducting an "enterprise"

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vision of the McCarran-Ferguson Act that renders the antitrust laws and other specifically-identified federal laws inapplicable in part if the State has regulated the insurance business, see pp. 3, 9, 25-26, *supra*. It has no bearing on whether a federal law would "invalidate, impair, or supersede" state law within the meaning of Section 2(b).

through a "pattern" of indictable criminal activity. 18 U.S.C. 1961, 1962.

Nor does RICO "impair" state law in any meaningful sense. Because the alleged conduct barred by RICO in this case is also prohibited by Nevada's insurance laws, RICO at most enhances vindication of state policy norms. State regulators sometimes work with federal prosecutors or seek redress under RICO themselves.[15] Moreover, RICO does not, by "increasing the probability that a state norm will be vindicated (or augmenting the damages assessed in the event of violation)," conflict with a state policy "that remedies should be limited or rare," *American Family*, 978 F.2d at 295; see Pet. Br. 23-24, or that administrative enforcement is preferred, see *Doe*, 107 F.3d at 1306-1307. No such policies are expressed with the requisite clarity (particularly with respect to a pattern of criminal conduct that could constitute a RICO violation), and no representative of the State appears before this Court so to claim.

Besides, Nevada's own law permits common-law actions for fraud and deceit in the insurance context—allowing for punitive awards that may far exceed actual damages in instances of malicious and oppressive misconduct—and expressly allows private rights of actions based on violations of its insurance laws. *Pioneer Chlor Alkali Co.* v. *National Union Fire Ins. Co.*, 863 F. Supp. 1237, 1243 (D. Nev. 1994); Nev. Rev. Stat. § 686A.310.2 (1997). Because those causes of action can "coexist" with the State's administrative enforcement of its insurance regulations, "even though the same conduct may be covered by both," there is "no reason why a

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[15] See, *e.g.*, *United States* v. *Employee Ins. Servs.*, Civ. No. 1-93-CV-181 (N.D. Ga., filed Jan. 27, 1989) (injunctive action brought with cooperation of state regulators); *Schacht* v. *Brown*, 711 F.2d 1343 (7th Cir.) (suit by Acting Director of Insurance of the State of Illinois as liquidator of insolvent insurer), cert. denied, 464 U.S. 1002 (1983); *Kaiser* v. *Stewart*, 965 F. Supp. 684 (E.D. Pa. 1997) (similar suit); *North Carolina* v. *Alexander & Alexander Servs., Inc.*, 680 F. Supp. 746 (E.D.N.C. 1988) (similar suit).

federal private right of action" under RICO "cannot coexist with" Nevada insurance law as well. *Sabo*, 137 F.3d at 195.[16]

* * * * *

The ordinary and eminently sensible presumption is that a federal law of general applicability such as RICO applies uniformly to all persons whose conduct falls within the statutory proscription. Under our system of equal justice under law, this is true regardless of the particular factual context or the particular State in which the conduct occurs, so long as Congress acts within its constitutional powers. The rule of statutory construction prescribed by the McCarran-Ferguson Act should not be distorted to create disuniformities in the application of other Acts of Congress—whether they be employment, safety, environmental, or civil rights laws, or prohibitions on criminal conduct—in the absence of a showing that the particular disuniformity is required to prevent a "state law regulating the business of insurance" from actually being "invalidate[d], impair[ed], or supersede[d]." Because no such showing has been made here—RICO's treble damages provision neither pre-empts nor effects a repeal of Nevada law—no disuniformity in the application of federal law is warranted or authorized under Section 2(b).

CONCLUSION

The judgment of the court of appeals should be affirmed.

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[16] As we explained in our amicus brief at the petition stage (at pp. 17-19), even if the McCarran-Ferguson Act precluded private parties from seeking treble damages—and it does not—neither civil nor criminal actions brought by the United States would be barred. To the contrary, the courts of appeals unanimously agree that government actions would remain permissible because the United States does not seek to remedy private harm, but to vindicate its sovereign interest in ensuring that the federal mails and other means of communication are not put to improper use; the United States need not rely on state law remedies to vindicate its sovereign interests.

Respectfully submitted.

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No. 97-303

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

HUMANA INC., and
HUMANA HEALTH INSURANCE OF NEVADA, INC.,
Petitioners,

v.

MARY FORSYTH, MARIETTA CADE,
WILLIE ANDREWS, MARY LOU BUEHLER,
HELEN STAVES, RANDOLPH BRATTON,
AND SEARLE AUTO GLASS, INC.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICI CURIAE* AND BRIEF OF ALLIANCE OF AMERICAN INSURERS, AMERICAN COUNCIL OF LIFE INSURANCE, BLUE CROSS AND BLUE SHIELD ASSOCIATION, HEALTH INSURANCE ASSOCIATION OF AMERICA, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES AND REINSURANCE ASSOCIATION OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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No. 97-303

In the
SUPREME COURT OF THE UNITED STATES
October Term, 1997

HUMANA INC. and
HUMANA HEALTH INSURANCE OF NEVADA, INC.,
Petitioners,

v.

MARY FORSYTH, MARIETTA CADE,
WILLIE ANDREWS, MARY LOU BUEHLER,
HELEN STAVES, RANDOLPH BRATTON,
AND SEARLE AUTO GLASS, INC.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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MOTION OF ALLIANCE OF AMERICAN INSURERS *ET AL.* FOR LEAVE TO FILE AN *AMICUS CURIAE* BRIEF IN SUPPORT OF PETITIONERS

Alliance of American Insurers, American Council of Life Insurance, Blue Cross and Blue Shield Association, Health Insurance Association of America, National Association of Independent Insurers, National Association of Mutual Insurance Companies and Reinsurance Association of America hereby move, pursuant to Rule 37 of this Court, for leave to file an *amicus curiae* brief in

support of Petitioners. The motion is necessitated by Respondents' refusal to consent.

The above-named associations are among the principal trade associations for the life, health, and property and casualty insurance industry in the United States. Their collective membership consists of thousands of insurance and reinsurance companies and health plans, ranging from small companies operating in single states to the largest insurers with operations nationwide and abroad. Together, these associations' members underwrite the vast majority of property and casualty and life risks in the United States, and provide a large percentage of the health benefits of groups and individuals throughout the nation.

As stated in the accompanying brief, the resolution of this case is of great significance to all of the *amici* and their members. This Court's interpretation of the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011 *et seq.* (1994), and in particular, the scope and meaning of the phrase "invalidate, impair, or supersede" in the statute, will help resolve a currently uncertain and divisive state of the law in the lower courts. Because the application to the *amici's* members of a federal statute that does not specifically relate to the business of insurance depends on the meaning of "invalidate, impair, or supersede" in the McCarran-Ferguson Act, the Court's interpretation of those terms here may very significantly define the scope of each of the *amici's* member's potential liability under federal law.

Alliance of American Insurers *et al.* believe their brief will provide the Court with relevant legal and factual information not already brought to the Court's attention by the parties, particularly with respect to the broad

significance of the question presented and a proper construction of the McCarran-Ferguson Act.

Respectfully submitted,

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INTERESTS OF AMICI CURIAE

Alliance of American Insurers, American Council of Life Insurance, Blue Cross and Blue Shield Association, Health Insurance Association of America, National Association of Independent Insurers, National Association of Mutual Insurance Companies and Reinsurance Association of America are among the principal associations of life, health, and property and casualty insurers in the United States. Together, their members underwrite the vast majority of property and casualty and life risks in the United States, and provide a large percentage of the health benefits of groups and individuals throughout the nation.

The resolution of this case is of great significance to all of the *amici* and their members. This Court's interpretation of the McCarran-Ferguson Act of 1945, and in particular, the phrase "invalidate, impair, or supersede" will help resolve a currently uncertain and divisive state of the law in the lower courts. Because the application to the *amici's* members of a federal statute, such as RICO, that does not specifically relate to the business of insurance depends on the meaning of "invalidate, impair, or supersede" in the McCarran-Ferguson Act, the Court's interpretation of those terms here may very significantly define the scope of each of the *amici's* member's potential liability under federal law.[1]

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[1] Respondents refused to provide consent to the filing of this brief. Accordingly, *amici* have submitted a motion for leave to file the brief. No counsel for any party in this case authored this brief in whole or in part, and no person or entity other than the *amici curiae* and their members made any monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

The Ninth Circuit in this case fundamentally misconstrued the meaning of "invalidate, impair, or supersede" in the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1012(b) (1994). The McCarran-Ferguson Act does not itself define the terms "invalidate," "impair," and "supersede." Accordingly, those terms should be given their ordinary meaning. *Asgrow Seed Co.* v. *Winterboer*, 513 U.S. 179, 187 (1995).

Rather than considering the ordinary meaning of the words "invalidate," "impair," and "supersede," in particular, by reference to dictionary definitions, the Ninth Circuit imparted its own chosen definition, interpreting all three words to mean "conflict." The McCarran-Ferguson Act does not use the term "conflict," however, nor does any dictionary of which *amici* are aware define either "invalidate," "impair," or "supersede" to mean "conflict." By reducing those three terms into a single, different meaning – conflict – the Ninth Circuit ignored both Congress' intent and this Court's directives regarding statutory interpretation. *See, e.g., Garcia* v. *United States*, 469 U.S. 70, 73 (1984) ("only the most extraordinary showing of contrary intentions . . . would justify a limitation on the 'plain meaning' of the statutory language").

The Ninth Circuit further failed to follow this Court's repeated directives to look to the provisions of a statute in its *entirety*, and to the statute's object and policy, in order to glean the proper construction of statutory terms. *See, e.g., United States Nat'l Bank of Ore.* v. *Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 455 (1993) ("In expounding a statute, we must . . . look to the provisions of

the whole law, and to its object and policy."). The object and policy of the McCarran-Ferguson Act, as the Act itself declares, is to ensure that "silence on the part of Congress shall not be construed to impose *any barrier* to the regulation or taxation of [the] business [of insurance] by the several States." 15 U.S.C. § 1011 (emphasis supplied). The Ninth Circuit's narrow interpretation of "invalidate, impair, or supersede" is inconsistent with this purpose.

The Ninth Circuit's narrow interpretation of "invalidate, impair, or supersede" stems from an erroneous theory that the McCarran-Ferguson Act operates under a rule of "inverse conflict preemption." Under this theory, the regulation of insurance by the states is deemed to "preempt" federal law only when there is an "irreconcilable conflict" between state law and federal law. This theory is overly simplistic, ignores the purpose of the McCarran-Ferguson Act, and is at odds with the fundamental principles of federalism that underlie *both* that Act and this Court's jurisprudence on federal preemption. Consistent with these principles, both the McCarran-Ferguson Act and federal preemption doctrine establish a strong presumption against federal statutory interference with state law absent clear congressional intent.

The Ninth Circuit's "inverse conflict preemption" theory perversely *reverses* this presumption, permitting federal laws of general application to interfere with state law *unless* there is an "actual conflict" with state law. Because this theory ignores circumstances when federal law may "invalidate," "impair," or "supersede" state law, such as exist in this case, the Ninth Circuit's approach effectively eviscerates the protection for state law that

Congress *expressly* created the McCarran-Ferguson Act to provide.

The profound effect of the Ninth Circuit's erroneous "inverse conflict preemption" theory is starkly illustrated in this case. Nevada has enacted specific laws to discipline insurer conduct, including prohibitions of fraud. *See* Nev. Rev. Stat. §§ 686A.030, 686A.040 (1997). These statutory prohibitions, as well as the corresponding prohibitions enacted by each of the other 49 states and the District of Columbia, are part of a carefully constructed system of individual state regulation designed to protect insurance policyholders not only from misleading insurer conduct, but also from, among other things, risks to the "solidity of insurers" and to "an adequate and healthy insurance market." *Id.* § 679A.140. Nevada, as well as each of the other states and the District of Columbia, has made distinct policy choices about how best to balance the often-competing interests of insurance policyholders in crafting its laws governing insurers. This balancing of interests, which this Court has recognized is inherent in the legislative process, *see Landgraf* v. *USI Film Products*, 511 U.S. 244, 286 (1994), is necessarily disturbed by the application of federal remedies to the same conduct which the states have chosen to discipline through *different* remedial means. The consequences are particularly grave here: not one state nor the District of Columbia has prescribed penalties for insurer fraud that are as inflexible and Draconian as those mandated by RICO.

The imposition of treble damages on insurers under RICO, which permits no discretionary mitigation to prevent undue harm to a defendant (in contrast to, for example, the imposition of punitive damages), demonstrably "invalidate[s]," "impair[s]," and "supersede[s]" state law

within the meaning of the McCarran-Ferguson Act. As this Court has previously recognized in the context of determining whether state law "stands as an obstacle" to full implementation of a federal statute, "it is not enough to say that the ultimate goal of both federal and state law is [the same]." *International Paper Co.* v. *Ouellette*, 479 U.S. 481, 494 (1987). An impermissible obstacle may be created if the state law "interferes with the *methods* by which the federal statute was designed to reach this goal." *Id.* Thus, under the Supremacy Clause, "whenever 'two separate remedies are brought to bear on the same activity' " by federal and state law, even complete harmony in the "substantive requirements" of the federal and state laws may not prevent preemption of the latter. *Wisconsin Dep't of Indus., Labor & Human Relations* v. *Gould, Inc.*, 475 U.S. 282, 286 (1986) (citation omitted).

Congress indisputably has the authority to intercede in governing the business of insurance whenever it sees fit. In the McCarran-Ferguson Act, Congress explicitly proscribed the interpretation of its enactments as exercising that authority absent congressional reference to the business of insurance in those enactments. The Ninth Circuit's narrow interpretation of the McCarran-Ferguson Act ignores the intent of Congress to thereby preserve state insurance regulation. Further, the Ninth Circuit's erroneous "inverse conflict preemption" theory finds no support in the language of the McCarran-Ferguson Act, the history of the statute's enactment, or this Court's precedents. Finally, the Ninth Circuit's approach in this case is inconsistent with the fundamental principles of federalism underlying both the McCarran-Ferguson Act and the relevant jurisprudence of this Court. For all these reasons, the decision below should be reversed.

ARGUMENT

I. THE NINTH CIRCUIT ERRED BY UNDULY LIMITING THE TERMS OF THE MCCARRAN-FERGUSON ACT

In the opinion below, the Ninth Circuit relied on its prior decision in *Merchants Home Delivery Service, Inc.* v. *Frank B. Hall & Co.*, 50 F.3d 1486 (9th Cir.), *cert. denied*, 516 U.S. 964 (1995), to find that the application of the federal Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. §§ 1961-1968 (1994 & Supp. I 1995), to practices that constitute the business of insurance is not precluded by the McCarran-Ferguson Act of 1945, 15 U.S.C. § 1011 *et seq.* (1994) ("McCarran"). Appendix to Petition ("App.") at 25a. In a relatively cursory few statements, the court below considered whether the application of RICO would, under McCarran, "invalidate, impair, or supersede" Nevada's legislation prohibiting fraudulent acts in the business of insurance. *See id.* at 24a-25a (citing the Nevada Trade Practices and Frauds; Financing of Premiums Act, Nev. Rev. Stat. § 686A.010 *et seq.* (1997)). The court observed "some symmetry" between RICO and the Nevada statute, noting that "RICO permits an injured plaintiff to recover for fraudulent practices which the Nevada administrative scheme proscribes." *Id.* Reasoning that this "symmetry" does not create a "conflict" between federal and state law, the court held that McCarran is not a bar to the plaintiffs' (Respondents') RICO claims. *Id.*

The Ninth Circuit's reasoning is overly simplistic, ignores the plain meaning of McCarran, and is at odds with the fundamental principles of federalism that underlie both McCarran and this Court's well-established jurisprudence

regarding the relationship between state and federal law. More specifically, the Ninth Circuit's narrow construction of the terms "invalidate," "impair," and "supersede" in McCarran cannot be squared with either congressional intent or this Court's prior interpretations of both McCarran and other statutes.

A. The Phrase "Invalidate, Impair, or Supersede" Does Not Mean "Conflict"

This Court has repeatedly emphasized that " 'the starting point in any case involving the meaning of a statute, is the language of the statute itself.' " *United States Dep't of the Treasury* v. *Fabe*, 508 U.S. 491, 500 (1993) (quoting *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210 (1979)). The McCarran-Ferguson Act provides, in pertinent part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance. . . .

15 U.S.C. § 1012(b).

McCarran does not define the terms "invalidate," "impair," and "supersede." Thus, in interpreting the statute, these terms should be given their ordinary meaning. *Asgrow Seed Co.* v. *Winterboer*, 513 U.S. 179, 187 (1995). In ordinary usage, each of these terms means something different than "conflict."

The Oxford English Dictionary, one of the dictionaries most frequently cited by this Court, *see, e.g.*, *Muscarello* v. *United States*, 118 S. Ct. 1911, 1914 (1998),

defines "invalidate," "impair," and "supersede" as follows: ***Invalidate***: "To render invalid; to destroy the validity or strength of (an argument, contract, etc.); to render of no force or effect; *esp.*, to deprive of legal efficacy; to make null and void." ***Impair***: "To make worse, less valuable, or weaker; to lessen injuriously; to damage, injure." ***Supersede***: ". . . To render superfluous or unnecessary; to preclude the necessity of. . . . To make of no effect; to render void, nugatory, or useless; to annul; to override. . . ."[2]

Webster's New International Dictionary, also frequently cited by this Court, *see, e.g.*, *Muscarello*, 118 S. Ct. at 1915; *Rutledge* v. *United States*, 517 U.S. 292, 299 n.10 (1996), defines the three terms as: ***Invalidate***: "to weaken or make valueless: DISCREDIT." ***Impair***: "to make worse: diminish in quantity, value, excellence, or strength: do harm to: DAMAGE, LESSEN." ***Supersede***: ". . . to make obsolete, inferior, or outmoded . . . to make void: ANNUL, OVERRIDE . . . to make superfluous or unnecessary. . . ."[3]

No dictionary, to the *amici's* knowledge, defines "invalidate," "impair," or "supersede" as "conflict."

Congress' choice to use the phrase "invalidate, impair, or supersede" cannot simply be brushed aside in order to justify the facially appealing (but seriously misguided) theory espoused by the Ninth Circuit here and

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2 The Oxford English Dictionary (2d ed. 1989).

3 Webster's Third New International Dictionary of the English Language (1964). *See also* Random House Dictionary of the English Language (2d ed. 1987).

in *Merchants Home* that McCarran operates just like the Supremacy Clause in reverse (the "inverse conflict preemption" theory). Had Congress intended McCarran to preclude the application of general federal laws only in the event of a direct "conflict" between state and federal law, it obviously could – and presumably would – have used the word "conflict" in McCarran. Instead, Congress chose to use three other, distinct terms.

By reducing the terms "invalidate," "impair," and "supersede" into a single, different word –"conflict" – the Ninth Circuit robbed the statutory terms of their ordinary significance and ignored the fact that Congress, by using the disjunctive "or," chose to make *each* of those terms a separate basis for the preservation of exclusive state law under McCarran. This was plainly error under this Court's precedents. *See Garcia* v. *United States*, 469 U.S. 70, 73 (1984) ("the use of the term 'or' indicates an intent to give the [words] their separate, normal meanings" (citing *Reiter* v. *Sonotone Corp.*, 442 U.S. 330, 338-39 (1979) ("In construing a statute we are obliged to give effect, if possible, to every word Congress used.")). *See also Doe* v. *Norwest Bank Minn.*, 107 F.3d 1297, 1308 (8th Cir. 1997) (properly looking to dictionary definition for meaning of "impair" and holding that RICO "impairs" state insurance law within the meaning of McCarran), *reh'g denied*, No. 97-1763 (May 12, 1997).

B. Congress' Stated Intent in Enacting McCarran Precludes a Narrow Interpretation of "Invalidate, Impair, or Supersede"

This Court has repeated " '[o]ver and over' " that " ' "[i]n expounding a statute, [courts] must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." ' " *Regions Hosp.* v. *Shalala*, 118 S. Ct. 909, 917 n.5 (1998) (quoting *United States Nat'l Bank of Ore.* v. *Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 455 (1993) (quoting *United States* v. *Heirs of Boisdore*, 8 How. 113, 122, 12 L. Ed. 1009 (1849))). The object and policy of the McCarran-Ferguson Act is to preserve from inadvertent federal interference the delicate and carefully constructed system of insurance regulation devised by the several states. Congress made that purpose very clear at the time it enacted McCarran:

> From its beginning the business of insurance has been regarded as a local matter, to be subject to and regulated by the laws of the several States. . . . There is urgent need for an immediate expression of policy by the Congress . . . so that the several States may know that the Congress desires to protect the continued regulation and taxation of the business of insurance by the several States.

S. Rep. No. 79-20, at 1-2 (1945); H.R. Rep. No. 79-68, at 1-2 (1945).

In *Merchants Home*, the Ninth Circuit began its analysis of McCarran by acknowledging that Congress intended the statute "to allow the states to regulate the

business of insurance free from inadvertent preemption by federal statutes of general applicability." *Merchants Home*, 50 F.3d at 1488-89 (citing *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 218 (1979)). However, neither the Ninth Circuit nor any of the other courts that have adopted the erroneous "inverse conflict preemption" theory in applying McCarran probed the statute's purpose sufficiently to consider why each and all of its terms "invalidate," "impair," and "supersede" were deliberately chosen by Congress.

This Court recently had occasion to consider the object and policy of McCarran in *Barnett Bank of Marion County* v. *Nelson*, 517 U.S. 25 (1996). In that case, the Court observed that McCarran "sets forth two mutually reinforcing purposes" by stating that " 'continued regulation and taxation by the several States of the business of insurance is in the public interest,' and that 'silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.' " *Id.* at 39 (quoting 15 U.S.C. § 1011). The latter phrase, the Court observed, reveals Congress' intent that McCarran serve to "protect state regulation primarily against inadvertent federal intrusion – say, through the enactment of a federal statute that describes an affected activity in broad, general terms, of which the insurance business happens to comprise one part." *Id.* RICO, of course, is such a federal statute, and thus its use in cases such as this squarely raises the question whether its application to insurance constitutes an "inadvertent federal intrusion."

Congress plainly recognized in enacting McCarran that, if it wished, it could preempt all state law governing the business of insurance. Indeed, McCarran was

Congress' near-immediate response to this Court's determination in *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), that such preemption was within Congress' Commerce Clause power. *See United States Dep't of Treasury* v. *Fabe*, 508 U.S. 491, 500 (1993) (in reaction to *South-Eastern Underwriters*, Congress "moved quickly to restore the supremacy of the States in the realm of insurance regulation"). McCarran is the expression of Congress' decision to leave state insurance regulation undisturbed by any federal law unless Congress has, in formulating that law, both "focused upon the insurance industry" and deliberately decided in favor of federal interference. *Barnett Bank*, 517 U.S. at 40. At the very least, Congress must make "specific detailed references to the insurance industry in proposed legislation" in order to overcome McCarran's bar on federal interference with state law, thereby guaranteeing "that Congress will have focused upon its insurance-related effects." *Id.* at 41-42.

Of course, this case does not involve the question whether RICO, like the federal banking statute at issue in *Barnett Bank*, "specifically relates to insurance."[4] But it is nevertheless critical in this case to recognize that in enacting McCarran, Congress affirmatively burdened itself with the responsibility to make clear when its own laws

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[4] Plainly, RICO does not specifically relate to insurance. There is not a scintilla of evidence suggesting that Congress ever contemplated the use of RICO to discipline the business of insurance. *Cf.*, *Barnett Bank*, 517 U.S. at 40-42 (finding that the National Bank Act "refers specifically to insurance"). Instead, Congress chose other laws for this purpose when it saw fit, including the criminal statute prohibiting fraud by persons "engaged in the business of insurance whose activities affect interstate commerce." 18 U.S.C. § 1033 (1994).

should be permitted to interfere with state insurance regulation. *See, e.g.*, 91 Cong. Rec. 481 ("Congress did not want . . . to take upon itself the responsibility of interfering with the taxation of insurance or the regulation of insurance by the States") (statement of Sen. Ferguson). Recalling this is key here because, as demonstrated by the divergent opinions of the Ninth, Seventh, and Third Circuits, on the one hand (*see Merchants Home;* 50 F.3d at 1492; *NAACP* v. *Am. Family Mut. Ins. Co.*, 978 F.2d 287 (7th Cir. 1992), *cert. denied*, 508 U.S. 907 (1993); *Sabo* v. *Metropolitan Life Ins. Co*, 137 F.3d 185 (3d Cir.1998), *petition for cert. filed*, 67 U.S.L.W. 3024 (June 29, 1998)), and the Eighth, Sixth, and Fourth Circuits on the other (*see Doe* v. *Norwest Bank, Minn., supra; Kenty* v. *Bank One, Columbus*, 92 F.3d 384 (6th Cir.), *reh'g denied*, No. 93-4211 (Sept. 19, 1996); *Ambrose* v. *Blue Cross & Blue Shield of Va., Inc.*, 95 F.3d 41 (4th Cir. 1996), *aff'g mem.* 891 F. Supp. 1153 (E.D. Va. 1995)), McCarran's "invalidate, impair, or supersede" language is subject to sharply different interpretations. Under this Court's dictates, the proper interpretation of this phrase will take into account the *overall* intent of Congress in enacting McCarran. *See Kokoszka* v. *Belford*, 417 U.S. 642, 650 (1974) ("When 'interpreting a statute, the court will not look merely to a particular clause in which general words may be used, but will take in connection with it the whole statute . . . and the objects and policy of the law, as indicated by its various provisions, and give to it such a construction as will carry into execution the will of the Legislature . . . .' " (quoting *Brown* v. *Duchesne*, 19 How. 183, 194, 15 L. Ed. 595 (1857))). As revealed by Congress' statements regarding McCarran and this Court's prior recognition of them, *see, e.g.*, *Fabe*, 508 U.S. at 499, 505, the terms "invalidate," "impair," and "supersede" must be broadly interpreted to protect federal laws from interfering with state regulation of insurance without prior

consideration and deliberation by Congress in favor of such intrusion.

C. The Theory of "Inverse Conflict Preemption" Is at Odds with the Fundamental Principles Underlying This Court's Jurisprudence on Preemption

The genesis of the erroneous decision below is the reasoning of the Seventh Circuit in *American Family*, relied on by the Ninth Circuit in *Merchants Home, see Merchants Home*, 50 F.3d at 1492, that "[t]he McCarran-Ferguson Act is a form of inverse preemption, so principles defining when state remedies conflict with (and so are preempted by) federal law are pertinent in deciding when federal rules 'invalidate, impair, or supersede' state rules." *American Family*, 978 F.2d. at 296. The fundamental flaw in the premise that McCarran prescribes the same rules as federal preemption doctrine, in reverse, is that the *policies* and *purposes* of McCarran militate directly against the application of such "inverse preemption" rules.

As described above, McCarran reflects Congress' deliberate decision to leave the regulation of the business of insurance to the states, undisturbed by any federal law that does not specifically relate to insurance. In enacting McCarran, Congress "clearly put the full weight of its power behind existing and future state legislation to sustain it from any attack under the commerce clause to whatever extent this may be done with the force of that power behind it, subject only to the exceptions expressly provided for." *Prudential Ins. Co.* v. *Benjamin*, 328 U.S. 408, 431 (1946). In taking this action, "Congress must have had full knowledge of the nationwide existence of state systems of regulation and taxation; of the fact that they differ

greatly . . . . [I]ts purpose was evidently to throw the whole weight of its power behind the state systems, notwithstanding these variations." *Id.* at 430.

Congress' purpose in enacting McCarran was wholly consistent with the principles of federalism that are at the heart of this Court's jurisprudence on preemption of state law by federal law. What is *not* consistent with *either* Congress' purposes for McCarran *or* this Court's federal preemption jurisprudence is the assumption that the *rules* of federal preemption should apply under McCarran directly in "reverse." Indeed, examined closely, it could hardly seem more perverse than to embrace this assumption, given the resulting intrusion on state authority.

In order to preserve the system of federalism, this Court requires that, in order for a federal law to preempt inconsistent state law, particularly an area historically regulated by the states, it must be clear, either expressly or implicitly, that Congress intended that result. To guard against unintended preemption of state law, the Court has identified three *narrow* circumstances in which such preemption may be found. The first is where Congress has expressly stated its intent to preempt. *E.g., Barnett Bank*, 517 U.S. at 31 (citing *Jones* v. *Rath Packing Co.*, 430 U.S. 519, 525, 530-31 (1977)). Second, congressional intent to preempt may be inferred from a "scheme of federal regulation 'so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it.' " *Id.* (quoting *Rice* v. *Santa Fe Elevator Co.*, 331 U.S. 218, 230 (1947)). Finally, state law is preempted to the extent that it is in "irreconcilable conflict" with federal law. *Id.* (citing *Rice* v. *Norman Williams Co.*, 458 U.S. 654, 659 (1982)).

By limiting federal preemption to cases involving only these three *narrow* circumstances, the Court has appropriately ensured that its preemption rules reflect traditional principles of federalism. As the Court has explained:

> Federal statutes impinging upon important state interests "cannot . . . be construed without the regard to the implications of our dual system of government. . . . over . . . local radiations in the vast network of our national economic enterprise and thereby radically readjusts the balance of state and national authority, those charged with the duty of legislating [must be] reasonably explicit."

BFP v. *Resolution Trust Corp.*, 511 U.S. 531, 544 (1994) (quoting *Kelly* v. *Robinson*, 479 U.S. 36, 49-50 n.11 (1986) (internal citation omitted)). *See also Gregory* v. *Ashcroft*, 501 U.S. 452, 460 (1991) ("if Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.' " (quoting *Will* v. *Michigan Dept. of State Police*, 491 U.S. 58, 65 (1989) (internal citations omitted)); *New York State Dep't of Soc. Servs.* v. *Dublino*, 413 U.S. 405, 413 (1973) (" 'If Congress is authorized in a field' it should manifest its intention clearly . . . . The exercise of federal supremacy is not lightly to be presumed.' " (quoting *Schwartz* v. *Texas*, 344 U.S. 199, 202-03 (1952))).

The federalism principles underlying this Court's preemption jurisprudence are precisely the same principles upon which McCarran is based. Just as this Court has established strict rules to protect state law from inadvertent preemption by federal law under the Supremacy Clause, so

Congress established in McCarran a statutory mandate to guard against inadvertent interference with state laws governing insurance. Theoretically, it may be appealing to analogize the McCarran rule against inadvertent federal interference with the judicial rule against inadvertent federal interference, but it makes *no* sense to apply the analogy *directly in reverse*. More specifically, *reversing* the "irreconcilable conflict" preemption rule under the Supremacy Clause and applying that reversed rule under McCarran eviscerates the protection for state law embedded in this Court's preemption jurisprudence *and* McCarran, because it shifts the presumption away from *preserving* state law to *allowing* federal law to *disrupt* traditional state regulation. If, under McCarran, a general federal law is to apply *unless* there is an "irreconcilable conflict" with state insurance law, the courts will begin their McCarran analyses with the plainly erroneous premise that Congress, in legislating on general matters, intends to regulate the business of insurance. Such a premise simply cannot be squared with McCarran or the principles of federalism the statute reflects.

In short, applying in "reverse" the "irreconcilable conflict" rule employed under the Supremacy Clause strikes at the heart of principles of federalism. It makes a mockery of this Court's jurisprudence. It turns the object and purpose of McCarran on its head.

II. THE NINTH CIRCUIT'S NARROW INTERPRETATION OF MCCARRAN SERIOUSLY THREATENS SOUND INSURANCE REGULATION BY THE SEVERAL STATES

A. State Regulation of the Business of Insurance Is Carefully Designed To Ensure a Sound Industry

The system of insurance regulation with which Congress expressly determined not to interfere when it enacted McCarran involves a carefully calibrated combination of laws designed, above all, to protect policyholder interests. As one court has explained:

> The insurance industry is regulated by the states. A particular insurance company must meet the various industry requirements of its home state, and must satisfy the requirements of all states in which it is qualified to act as an insurer. The state requirements include standards for investments, maintenance of reserves, and accounting practices. The state insurance departments supervise policy forms, agency relationships, and the general financial activities of the companies within their jurisdictions. This regulation is designed to preserve the solvency of the insurance companies for the protection of the policyholders.

Consumer Life Ins. Co. v. *United States*, 524 F.2d 1167, 1171 (Ct. Cl. 1975).

As this case highlights, insurer solvency is not the only interest of policyholders that state insurance regulation

serves to protect. Indeed, the Nevada insurance statute, the state law at issue here, sets forth as among its key purposes not only to "provide adequate standards of solidity of insurers," to "insure that the state has an adequate and healthy insurance market," and to "improve and thereby preserve state regulation of insurance," but also to "prevent misleading, unfair and monopolistic practices in insurance operations." Nev. Rev. Stat. § 679A.140 (1997). The Nevada Trade Practices and Frauds; Financing of Premiums Act specifically proscribes misrepresentations by insurers to ensure such protection. *See id.* at §§ 686A.030, 686A.040. Each of the other 49 states similarly prohibits fraud and each has an unfair trade practices statute that proscribes a wide variety of unfair conduct by insurers. However, the different states have devised distinct methods for enforcing these prohibitions, including through different penalties.

The states' choice of specific remedies for policyholders harmed by insurer misconduct is key to effective state insurance regulation. A state's decision to permit private rights of action against insurers, for example, obviously reflects a particular policy determination with respect to competing interests of insureds. Likewise, and most pertinent here, individual states determine what types of penalties to authorize based on their assessments of how best to discipline insurers while at the same time not endangering insurers' financial health. The balance struck by state legislatures in this regard reflects precisely the type of compromise that this Court has previously recognized is frequently necessary in promulgating legislation. *See, e.g.*, *Landgraf* v. *USI Film Prods.*, 511 U.S. 244, 286 (1994) ("Statutes are seldom crafted to pursue a single goal, and compromises necessary to their enactment may require adopting means other than those that would most

effectively pursue the main goal."). Tellingly, not one of the states, in deciding how best to prevent fraudulent conduct by insurers, has prescribed remedies as inflexible and Draconian as those mandated by RICO.[5]

One example of the states' special means of disciplining insurers is the use of "market conduct" examinations. State insurance departments regularly undertake these examinations to probe a variety of underwriting, marketing, and claims settlement practices. The examinations culminate in the production of formal reports setting forth the regulators' findings and identifying any failures to conform to state statutory or regulatory mandates. Depending on the circumstances and the severity of nonconforming conduct, an insurer found to be out of compliance may be subject to penalties, required to enter into a consent decree, or otherwise be ordered to take corrective action.

A recent example of a novel use of the market conduct examination process and the cooperation of state insurance regulators in settling policyholder claims of fraud is the settlement approved by the Third Circuit in *In Re Prudential Insurance Co. American Sales Practice Litigation Agent Actions*, Nos. 97-5155, 97-5156, 97-5217, 97-5312, 1998 WL 409156 (3d Cir. Jan. 23, 1998). That case involved a nationwide class action alleging deceptive

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5 The states' determination of proper penalties for insurer fraud may reflect, among other things, considerations regarding optimal damages for deterrence purposes. *See, e.g.*, A. Mitchell Polinski and Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 *Harv. L. Rev.* 869 (1998) (analyzing the costs and benefits to society of various levels of punitive damages imposed on corporate defendants).

sales practices throughout all of the 50 states and the District of Columbia. At the outset of the case, the New Jersey Insurance Commissioner initiated the organization of a group of insurance regulators from the several states, in which 30 states and jurisdictions elected to participate. The group's work culminated in a report (Report of the Multi-State Life Insurance Task Force and Multi-State Market Conduct Examination of the Prudential Insurance Company of America) that recommended a remediation plan, developed with Prudential's input and cooperation, for settlement of the nationwide claims. *Id.* at *2-*3.

The state regulators' role in the *Prudential* case exemplifies the importance to the states of policing insurer conduct in a manner that appropriately accounts for policyholders' interests in the ongoing solvency of insurers and at the same time ensures adequate discipline of allegedly unlawful insurer conduct. The application of RICO, whose treble damage awards provide for no flexibility, mitigation, or waiver, affords no opportunity for the balancing of interests that state insurance regulation provides. Indeed, courts adjudicating RICO claims do not even have the discretion afforded to courts imposing *punitive* damage awards to consider whether mitigation may be warranted to prevent excessive financial harm to the defendant. *See, e.g.*, *Cullen* v. *Margiotta*, 811 F.2d 698, 713 (2d Cir.) (RICO "requires" that the successful plaintiff be awarded treble damages), *cert. denied*, 483 U.S. 1021 (1987); *Rowlett* v. *Anheuser-Busch, Inc.*, 832 F.2d 194, 207 (1st Cir. 1987) (factors to be considered in awarding punitive damages include the "solvency of the guilty party"). As discussed further below, the application of RICO in a case such as this, in which Nevada has specifically chosen to punish insurer fraud in a different manner than RICO mandates, "impair[s]" (*i.e.*, "does harm

to," "diminishes in value," and "lessens injuriously") state law within the meaning of McCarran by eliminating such discretion.

B. The Imposition of RICO Penalties in This Case and in Others Impairs State Law Within the Meaning of McCarran

The narrow interpretation of McCarran adopted by the Ninth, Seventh and Third Circuits led those courts to the erroneous conclusion that the imposition of treble damages awards under RICO does not "invalidate, impair, or supersede" state law. These courts and the lower courts that have similarly "legislated" that McCarran means "conflict" when it says "invalidate, impair, or supersede" have failed to acknowledge the disruption in state law that the application of RICO penalties to insurers effects, and therefore to recognize why RICO is precisely the type of federal statute Congress declared should *not* apply to insurers in cases such as this.

A brief comparison of RICO to the state laws at issue in this case, *Merchants Home*, and *Sabo* is instructive. Under RICO's provision for a private right of action,

> Any person injured in his business or property by reason of a [pattern of racketeering activity] . . . may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee . . . .

18 U.S.C. § 1964(c).

As noted, RICO affords no discretion to the court with respect to treble damages awards. Due to

policyholders', and thus the states', interests in insurers' solvency, this inflexibility of RICO is particularly significant in the insurance context.

The state fraud laws at issue here, in *Merchants Home*, and in *Sabo,* all operate very differently than RICO. Under the Nevada law in this case, if the insurance commissioner believes that anyone has engaged or is engaging in unfair insurance practices, he may issue a statement of charges, accompanied by a notice of hearing. Nev. Rev. Stat. § 686A.160 (1997). Following a hearing, the commissioner is required to issue his order, and if he determines that a violation has occurred, he may order the person to cease and desist from engaging in the unfair practice. *Id.* § 686A.183. The Commissioner may also impose one or both of the following types of penalties:

> (a) If the person knew or reasonably should have known that he was in violation of [the law], payment of an administrative fine of not more than $5,000 for each act or violation, except as to licensed agents, brokers, solicitors and adjusters, the administrative fine must not exceed $500 for each act or violation.
>
> (b) Suspension or revocation of the person's license if he knew or reasonably should have known that he was in violation of [the law].

Id.

Additionally, should the commissioner simply order the person to cease and desist, the commissioner retains the authority to impose the aforementioned penalties in the event that the cease-and-desist order is violated. *See id.*

§ 686A.187. Nevada also provides a private right of action for parties who have been injured by the unfair practices of an insurer, but not for the recovery of treble damages. *Id.* § 686A.310.2.

Similar limitations on penalties apply under the California law at issue in *Merchants Home*. Under the California insurance statute, a person engaging in unfair insurance practices "is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand ($5,000) for each act." Cal. Ins. Code § 790.035(a) (1993). If the unfair act or practice is determined to be willful, "a civil penalty not to exceed ten thousands dollars ($10,000) for each act" may be applied. *Id.* The determination and the imposition of the penalty is to be decided solely by the insurance commissioner. *Id.* § 790.035(b). Penalties also may be imposed by the commissioner in the event of a violation of any cease-and-desist order the commissioner may impose. *Id.* § 790.07. These penalties too are capped in amount by statute. *See id.*

Likewise, the Pennsylvania unfair practices statute implicated in *Sabo* authorizes the insurance commission to impose fines that are capped at a maximum amount, for knowing violations, of $50,000 in any six-month period. 40 Pa. Cons. Stat. § 1171.11 (1992). Pennsylvania common law further provides a private right of action for fraudulent conduct, but does not authorize treble damages or attorneys' fees. *See Wexco Inc.* v. *IMC, Inc.*, 820 F. Supp. 194, 203-04 (M.D. Pa. 1993). Courts *may* award *up to* treble damages and attorneys' fees in cases brought under the Pennsylvania Consumer Protection Law, 73 Pa. Cons. Stat. § 201-9.2 (1993), but such awards are not

mandatory, as they are under RICO. *See Sewak* v. *Lockhart*, 699 A.2d 755 (Pa. Super. Ct. 1997).

In this case, the district court properly found that, because Nevada "does not prescribe the same harsh penalties which would be available under RICO (*e.g.* treble damages and attorney's fees) for Defendants' violation of unfair trade practices [prohibitions] . . . the McCarran-Ferguson ['invalidate, impair, or supersede'] test is met." App. at 94a-95a (citations omitted). The district court accurately recognized:

> For this Court to allow Plaintiffs to pursue the harsher RICO penalties for behavior which the Nevada Legislature apparently did not deem worthy of such penalties, would be tantamount to allowing Congress to intercede in an area expressly left to the states under the McCarran-Ferguson Act.

Id. at 95a.

In reaching this conclusion, the district court looked to the opinions of other district courts addressing the same issue, including the District Court for the Northern District of California in *LeDuc* v. *Kentucky Central Life Ins. Co.*, 814 F. Supp. 820 (N.D. Cal. 1992), and the District Court for the Middle District of Pennsylvania in *Wexco, Inc.* v. *IMC, supra.* These two opinions merit particular note because they involved the California law at issue in *Merchants Home* and the Pennsylvania law at issue in *Sabo*. Indeed, the district court in *Merchants Home* also cited *LeDuc* in its analysis of the McCarran issue. *See Merchants Home Delivery Serv., Inc.* v. *Reliance Group Holdings*, No. CV-92-6889-WMB, slip op. at 10a (C.D. Cal. July 24, 1993) (finding that the plaintiff's RICO

claims were barred by McCarran because "RICO contains provisions for treble damages and attorneys' fees, neither of which are allowed under the California statutory scheme . . . RICO would not just provide 'parallel' remedies . . . it would supersede the state remedies.").

The opinions in *LeDuc* and *Wexco* set forth the proper analysis of whether RICO "invalidate[s], impair[s], or supersede[s]" state law within the meaning of McCarran. The district courts in these cases and the Sixth, Eighth, and Fourth Circuits in *Kenty, Doe*, and *Ambrose*, respectively, properly construed the operative language in McCarran to mean more than "conflict." As these courts have recognized, the application of RICO in cases where state law authorizes penalties for fraud that differ from the mandatory treble damages and attorneys' fee awards prescribed by RICO "upsets the balance" of regulation of the business of insurance that the states have carefully constructed. This point was aptly made by the court in *Wexco*:

> While Pennsylvania courts have held that . . . common law fraud and deceit actions [are] . . . viable options for aggrieved insureds . . . such common law actions do not reward plaintiffs with the treble damages, costs and attorney fees mandated by RICO. The availability of a federal private action under RICO would not merely nullify the state's chosen regulatory remedies for insurance entity misconduct. Rather, this court believes that the availability of a federal private remedy which would reward successful business plaintiffs, such as the captioned parties, with treble damages, costs and attorney fees *cannot help but upset the balance of relationships between insurance entities and*

> *insureds which are established and regulated* by . . . state laws . . . .

Wexco, 820 F. Supp. at 203-04 (emphasis supplied). *See also LeDuc*, 814 F. Supp. at 829 ("applying RICO would nullify the state's determination of the appropriate remedies for certain conduct and would supersede remedies and regulatory supervision provided by California law. In addition, *California's comprehensive regulatory supervision of insurers' financial conditions would be undermined and disrupted* if agents and policyholders were permitted to assert federal RICO claims based upon allegations of financial nondisclosure.") (emphasis supplied).

This Court, in other contexts, has similarly recognized that the application of remedies inconsistent with those prescribed by the laws of a particular authority may "alter the balance" struck by that authority. As the Court stated with respect to recognizing a right to contribution under federal common law in *Northwest Airlines, Inc.* v. *Transport Workers Union of America,* 451 U.S. 77 (1981), " '[i]t is not our place simply to alter the balance struck by Congress in procedural statutes by . . . enlarging on the remedial provisions contained in these carefully considered statutes.' " *Id.* at 98 (quoting *Mohasco Corp.* v. *Silver*, 447 U.S. 826 (1980)). Likewise, in considering the significance of different remedies in the federal preemption context, the Court has recognized that, in determining whether state law "stands as an obstacle" to full implementation of a federal statute, "it is not enough to say that the ultimate goal of both federal and state law is [the same]." *International Paper Co.* v. *Ouellette*, 479 U.S. 481, 494 (1987). Such an obstacle may be created if the state law "interferes with the *methods* by which the federal

statute was designed to reach this goal." *Id.* In many cases, permitting state remedies not authorized by a federal statute would invite circumvention of the federal statute, "thereby *upsetting the balance of public and private interests so carefully addressed by the [statute].*" *Id.* (emphasis supplied). *See also Amalgamated Ass'n of Street, Elec. Ry. & Motor Coach Employees of Am.* v. *Lockridge*, 403 U.S. 274, 287 (1971) ("Conflict in technique can be fully as disruptive . . . as conflict in overt policy. . . . The technique of administration and the range and nature of those remedies that are and are not available is a fundamental part and parcel of the operative legal system . . . ."); *Wisconsin Dep't of Indus., Labor & Human Relations* v. *Gould Inc.*, 475 U.S. 282, 286 (1986) ("Because 'conflict is imminent' whenever 'two separate remedies are brought to bear on the same activity,' . . . [the Supremacy Clause] prevents States not only from setting forth standards of conduct inconsistent with the substantive requirements of [a federal statute governing certain activity], but also from providing their own regulatory or judicial remedies for conduct prohibited or arguably prohibited by the [federal statute].")

Under this Court's analytical precedents, therefore, the application of RICO in cases such as this demonstrably "impairs" state law. It was these precedents that implicitly informed the opinion of the district court in *Ambrose*, which the Fourth Circuit affirmed without opinion. As the district court in *Ambrose* stated regarding the erroneous "inverse conflict preemption" theory applied by the Ninth, Seventh, and Third Circuits:

> [T]he premise that federal and state laws that prohibit the same conduct "but differ in penalty do not conflict with or displace each other," *American*

> *Family*, 978 F.2d at 297, seems to be based on a very narrow reading of the purpose and function of the state laws at issue. Virtually any state statute includes more than a simple proscription of conduct. It includes the appropriate penalty for that conduct and the appropriate mechanism for enforcing the proscription. A state law that prohibits an act, punishes it with a specific range of fines, makes it the subject of remedial action, and vests enforcement in a state quasi-judicial entity cannot be said to be consistent with a federal law that prohibits the same act, permits treble damages, fees, and costs, and expressly creates a personal cause of action. If *Nationwide, Merchants Home Delivery* and *American Family* are construed to hold otherwise, their lead cannot be followed here.

Ambrose, 891 F. Supp. at 1167. *See also Doe*, 107 F.3d at 1307-08 ("The state of Minnesota has determined that its insurance market can best be regulated by the Commissioner's pursuit of fines and injunctive relief. . . . [T]he extraordinary remedies of RICO would frustrate, and perhaps even supplant, Minnesota's carefully developed scheme of regulation. We do not read the term 'impair' so narrowly as to permit the conclusion that the McCarran-Ferguson Act does not apply in the circumstances presented here."); *Kenty*, 92 F.3d at 392 ("RICO calls for treble damages, which Ohio law does not . . . applying RICO to insurance companies . . . would impair the regulatory framework within which Ohio expects its insurance companies to do business.").

This Court, as demonstrated above, has already supplied principled reasons for reversing the court below. The Ninth Circuit's narrow interpretation of "invalidate,

impair, or supersede" in McCarran cannot be reconciled with Congress' mandate against inadvertent interference by federal law with state insurance regulation, and the principles of federalism that mandate reflects. The Ninth Circuit's reading of McCarran is fundamentally flawed and should be rejected.

CONCLUSION

Amici respectfully urge the Court to reverse the decision below and to hold, in particular, that the "inverse conflict preemption" theory applied by the Ninth Circuit is an erroneous framework for analyzing when a federal law may "invalidate, impair, or supersede" state law within the meaning of the McCarran-Ferguson Act.

Respectfully submitted,

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No. 97-303

In The

Supreme Court of the United States

October Term, 1997

HUMANA INC. and HUMANA HEALTH INSURANCE OF NEVADA, INC.,

Petitioners,

vs.

MARY FORSYTH, MARIETTA CADE, WILLIE ANDREWS, MARY LOU BUEHLER, HELEN STAVES, RANDOLPH BRATTON and SEARLE AUTO GLASS, INC.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION OF THE CONSUMER CREDIT INSURANCE ASSOCIATION FOR LEAVE TO FILE BRIEF OUT OF TIME AND FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITION AND BRIEF *AMICUS CURIAE*

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Pursuant to Rule 37.3(a) of the Rules of the Supreme Court of the United States, the Consumer Credit Insurance Association ("CCIA") respectfully requests leave to submit the accompanying *amicus curiae* brief, which presents four surveys of state laws which will be superseded or impaired if this Court does not vacate and reverse the decision below.[1] These surveys are not included or referenced in the "Brief on the Merits of Petitioners" ("Petitioners' Brief"). The surveys demonstrate that: (1) almost all states have specifically enacted comprehensive laws to regulate the business of insurance in accordance with the McCarran-Ferguson Act; (2) almost all states have specifically enacted laws regulating misrepresentations and other unfair or deceptive acts in the business of insurance; (3) almost all states have laws requiring that insurers submit policy forms for approval by the state insurance departments; and (4) almost all states have laws requiring that insurers submit premium rates for approval by the state insurance departments. These surveys present a small but very important segment of the universe of state insurance laws which stand to be impaired or superseded if this Court declines to reverse the decision below. Because this information is likely to be very useful to the Court in its evaluation of the question presented, and because this information is unlikely to be presented to the Court by the parties, the CCIA respectfully requests that the Court grant this motion and permit it to submit the accompanying *amicus* brief.

Furthermore, this Court's decision in this case will have an enormous impact on other cases presently pending in lower courts. For example, a large number of cases challenging an insurance product known as non-filing insurance have been

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1. Petitioners have consented to the submission of the CCIA's *amicus* brief. CCIA's counsel has attempted diligently to contact Respondents' counsel but has not been able to do so.

consolidated under the Multi-District Litigation procedure in the United States District Court for the Middle District of Alabama under the caption *In Re: Consolidated "Non-Filing Insurance" Fee Litigation*, MDL Docket No. 1130.[2] The claims asserted in that consolidated multi-district non-filing insurance litigation are essentially RICO and TILA (Truth in Lending Act, 15 U.S.C. §§ 1601, *et seq.*) claims. Because neither RICO nor TILA specifically relates to the business of insurance, the Court's decision in this case will have a potentially decisive impact on the multi-district non-filing insurance litigation. Some of the CCIA's members are parties to cases pending in the lower courts, and the CCIA requests leave to present their position by way of the *amicus* brief.

For the foregoing reasons, the CCIA also requests leave to submit the proposed *amicus* brief out of time. Under the Court's Rules, the CCIA's brief would have been due on August 6, 1998. The CCIA timely submitted a motion for enlargement of time pursuant to Rule 30 of the Court's Rules. This brief is being submitted on August 11, 1998. Copies of the *amicus* brief have been served on all counsel of record by Express next-day delivery through the U.S. Mail. Thus, the prejudice to the respondents is minimal, if any. Given the potentially wide-ranging and decisive consequences of the Court's decision for insurers in general, and the CCIA's members in particular, the Court's consideration of the question presented will be aided by the state surveys and special perspectives presented in the *amicus* brief. Therefore, the CCIA respectfully requests that the Court grant it leave to submit the accompanying *amicus* brief out of time. *Cf. Booth v. Maryland*, 479 U.S. 1081 (1987) (granting motion for leave to file *amicus* brief out of time); *Johnson v. Transportation Agency*, 479 U.S. 912 (1986); *Goldstein v. California*, 414 U.S. 883 (1973) and 409 U.S. 976 (1972).

2. Non-filing insurance is an insurance product which protects lenders from the risk of loss arising from their inability to recover the collateral for the loan due to the failure to perfect a security interest in the collateral. In part, because of high transactional costs associated with the recording and subsequent releasing of security interests in certain types of collateral, lenders prefer to obtain non-filing insurance. Although non-filing insurance policies have been filed with, and approved by, virtually every state, the plaintiffs in the consolidated multi-district non-filing litigation have asserted claims against more than a dozen insurers (and more than fifty creditors) on behalf of a national class of borrowers.

Respectfully submitted,

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INTEREST OF *AMICUS CURIAE*[1]

The Consumer Credit Insurance Association ("CCIA") is a national organization with more than 180 insurance companies as members. The insurance policies and premium rates used by the CCIA's members are typically filed with and approved by state insurance departments in accordance with governing state statutes.[2] The CCIA's members rely upon the various states' approvals of their policy forms and premium rates in conducting their business. In addition, most states, like Nevada, have expressly adopted comprehensive codes to regulate alleged unfair trade practices in the insurance industry, including misrepresentations concerning the terms of an insurance policy.[3] The CCIA's members are subject to these state unfair insurance practices laws and are subject to the various penalties included therein which may be levied by the state insurance commissioners, including fines and the suspension or revocation of the license to transact business in the state.

The McCarran-Ferguson Act assures the CCIA's members that when they act with regard to the policyholder-insurer

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1. This *amicus* brief has not been authored in whole or in part by counsel for any of the parties. Monetary support for the preparation and submission of this brief was provided by American Bankers Insurance Company of Florida, a member of the CCIA.

2. Surveys of state statutes requiring the filing and approval of policy forms and premium rates are appended to this brief in Appendices A and B.

3. A survey of states which have expressly enacted insurance regulatory laws in response to the McCarran-Ferguson Act is appended to this brief as Appendix C; and a survey of states which have enacted legislation to regulate misrepresentations with regard to insurance policies is appended to this brief as Appendix D.

relationship, and conform to state laws regulating that relationship, they will not be subject to lawsuits based on the alleged violation of general federal laws, such as RICO. This assurance is an important part of the risk matrix analysis undertaken by the CCIA's members in offering a given insurance product, and of the costs which must be taken into account in developing premium rates. The decision of the Ninth Circuit Court of Appeals in the instant case severely erodes those assurances and threatens to force a major change in the way the state departments of insurance and the CCIA's members conduct the business of insurance. The effects of such changes will be felt not only by the CCIA's members, but by the insurance industry as a whole. Ultimately, all consumers of insurance are likely to bear the economic consequences of such changes.

Furthermore, this Court's ruling on the question presented will have a decisive impact on other cases which are presently before the lower courts, and in which the CCIA's members are either directly involved as parties, or their insurance products have been challenged under federal laws which do not specifically relate to the business of insurance. For these reasons, the CCIA has a substantial interest in these proceedings.

SUMMARY OF THE ARGUMENT

The Ninth Circuit's decision in the case below holds that the McCarran-Ferguson Act (the "Act") does not preclude the application of RICO to alleged misrepresentations concerning an insurance policy even though state law regulates the conduct in question, because RICO is not in "direct conflict" with the state law and, therefore, does not invalidate, impair or supersede the state law. According to the Ninth Circuit, there is a "symmetry" between RICO remedies and the remedies provided by state law, and such symmetry does not create a conflict

between RICO and state law such as will cause preclusion of RICO under the McCarran-Ferguson Act.

The Ninth Circuit's analysis is fatally flawed because it ignores the express language and purposes of the McCarran-Ferguson Act, and shifts the focus of the analysis from whether relevant state law exists to whether federal and state laws are incompatible. Because it finds that RICO remedies are not directly incompatible with the remedies provided by state law, the Court below finds that RICO may be applied as a parallel insurance review system. In doing so, the Ninth Circuit creates an alternative federally-based system for addressing alleged fraud and unfair practices in the business of insurance, and defeats the principal purpose of the Act, which was to leave the regulation of the business of insurance to the states unless Congress enacted a law which specifically relates to the business of insurance.

The "Brief on the Merits of Petitioners" ("Petitioners' Brief") cogently argues: (1) that the "inverse" preemption analysis applied by the Ninth Circuit Court of Appeals in the decision below is logically flawed and produces perverse results; and (2) that ordinary rules of statutory interpretation should be applied to the McCarran-Ferguson Act. While avoiding repetition of those arguments, this brief adds to the analysis by showing that the text of the McCarran-Ferguson Act itself sets forth the following purposes: first, the Act "returns" the field of insurance regulation and taxation to the states and, second, it withdraws Congress's legislative power over that field, except when Congress expressly speaks otherwise by enacting a statute which specifically relates to the business of insurance. Thus, the Act's specific concern was to ensure that a federal forum was *not* available for the resolution of disputes concerning the business of insurance, except when Congress indicated by specific legislation it wished to do so. Because the "direct-

conflict" test creates a federal forum and permits the application of federal laws to the business of insurance even when the federal statute, RICO here, does not specifically relate to the business of insurance, this test frustrates the accomplishment of the purposes of the McCarran-Ferguson Act, and this Court should reject that test.

Additionally, this brief presents four surveys of state insurance laws which demonstrate that the states (including Nevada, the state whose laws are directly at issue in this case) have adopted comprehensive laws to regulate the business of insurance, and in particular, conduct which is alleged to be deceptive or a misrepresentation of the terms of an insurance policy. The application of RICO in the face of state law which admittedly regulates the alleged conduct here, impairs or supersedes the state insurance codes, including state laws which specifically regulate unfair insurance trade practices and alleged misrepresentations with regard to the business of insurance — laws which the states expressly enacted pursuant to the McCarran-Ferguson Act. The impairment occurs because RICO provides remedies which are far more attractive to aggrieved policyholders than the remedies provided by state insurance codes. As a result, policyholders will ignore the redress systems provided by the states and will sue their insurers for RICO damages in most disputes. Thereby, the state insurance regulatory schemes will have been supplanted and superseded by operation of the federal RICO statute. Instead of disputes between policyholders and their insurers being resolved by the states' chosen mechanisms, federal courts will henceforth become the main forum for the resolution of those disputes.

Finally, this brief presents the viewpoint of the CCIA's members, who not only must comply with state insurance laws regulating the business of insurance, but now, if the Ninth

Circuit's decision stands, will also have new exposure under general federal laws which do not specifically relate to the business of insurance, and whose application to the insurer-insured relationship has hitherto been precluded under the McCarran-Ferguson Act. This will make insurers, including the CCIA's members, reluctant to resolve disputes over alleged violations with regard to the business of insurance through the intermediation of the state insurance commissioners, because such resolution could compromise the insurers' defenses in pending or threatened RICO litigation. Thus, application of RICO to the business of insurance would further impair the states' traditional regulation of the insurance industry.

ARGUMENT

I.

THE "DIRECT-CONFLICT" TEST THWARTS THE PRINCIPAL PURPOSE OF THE McCARRAN-FERGUSON ACT AND CREATES AN ALTERNATIVE FEDERAL SYSTEM FOR THE REGULATION OF THE BUSINESS OF INSURANCE.

In the case below, the Ninth Circuit, following its previous decision in *Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486 (9th Cir.), *cert. denied*, 116 S. Ct. 418 (1995), held that the application of a federal statute which prohibited conduct also prohibited under a state's insurance law did not "invalidate, impair, or supersede" the state's laws under the McCarran-Ferguson Act. *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1480 (9th Cir. 1997). This decision is wrong because neither the express language of the Act nor its purposes provides any support whatsoever for that rationale. Indeed, because the decision below opens up a parallel federal system for redressing alleged fraud and unfair practices in the business

of insurance, it thwarts the main purpose of the McCarran-Ferguson Act, which was to leave the regulation of the business of insurance to the states, and to provide no federal forum for resolution of disputes concerning the business of insurance, except when Congress enacted a law specifically relating to the business of insurance.

Two interrelated purposes are apparent on the face of the McCarran-Ferguson Act.[4] First, Congress intended that States would continue to regulate and tax "the business of insurance" just as they had done prior to *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944); and, second, that no Act of Congress would "invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance" except if the Act of Congress "specifically relates to the business of insurance."

The *first* purpose was expressed in 15 U.S.C. §§ 1011 and 1012(a), which state, in sequence, as follows:

> Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest. . . .

15 U.S.C. § 1011.

> **(a) State regulation**
>
> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

15 U.S.C. § 1012(a).

4. Petitioners' Brief demonstrates that the "direct-conflict" test is not faithful to the plain terms of the McCarran-Ferguson Act and that the Act's terms provide no basis for narrowing the scope of the Act by limiting it to cases of direct conflict between federal and state laws. This brief, therefore, does not repeat those arguments.

These statutory texts make amply clear that Congress was "returning" the field of insurance regulation and taxation to the states, which had been the sole regulators of that industry until *South-Eastern Underwriters*. The governing law prior to *South-Eastern Underwriters*, had been enunciated in *Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868), which had held that the issuance of insurance contracts was not a transaction in interstate commerce and, therefore, those contracts were not subject to federal authority emanating from the Commerce Clause. *Paul* confirmed that insurance contracts were "local transactions, . . . [which] are governed by the local law." 75 U.S. (8 Wall.) at 183. *South-Eastern Underwriters*, however, demolished that legal axiom by holding that Commerce Clause jurisdiction did extend to the issuance of insurance contracts. *United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 499 (1993). It was to undo the potential vitiation of traditional state regulation of the insurance industry caused by *South-Eastern Underwriters* that Congress expressly declared that the continued regulation of insurance by the States was in the public interest, and that the insurance industry *shall* be subject to the laws of the States. These provisions made clear that, in Congress's view, federal regulation of the business of insurance was not in the public interest and that the business of insurance would not be subject to federal laws unless, as set forth in § 1012(b), Congress expressly spoke otherwise by enacting a law specifically relating to the business of insurance.

Furthermore, because *South-Eastern Underwriters* had interpreted the Commerce Clause as extending Congress's legislative power to the insurance business, Congress expressly

enacted language to give effect to its *second* purpose, which was the *withdrawal* of Congressional legislative power from the field of insurance regulation and taxation, *except* when Congress expressly spoke otherwise. Accordingly, § 1012(b) laid down the rule that

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . .

15 U.S.C. § 1012(b). Section 1011 added support to this rule by explaining that "silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." The sole exception to this Congressional withdrawal of its legislative power was any "Act [which] specifically relates to the business of insurance." All other Acts of Congress, *i.e.* "general" federal statutes, by the express terms of the McCarran-Ferguson Act, did not apply to the business of insurance so long as state statutes had been enacted to regulate that business.[5]

This Court itself has subscribed to the above propositions. It has stated, for instance, that "the McCarran-Ferguson Act *exempts* the insurance industry from Commerce Clause restrictions", *Metropolitan Life Ins. Co. v. Ward*, 470 U.S. 869, 880 (1985) (emphasis added); and that "the McCarran-Ferguson Act *removes entirely* any Commerce Clause restriction upon [the States'] power to tax the insurance business" and "[t]he McCarran-Ferguson Act simply ma[kes] the Commerce Clause *inapplicable*" to the business of insurance. *Western & S. Life Ins. Co. v. State Bd. of Equalization*, 451 U.S. 648, 655

5. Petitioners' Brief discusses the legislative history of the McCarran-Ferguson Act and demonstrates that the Act's history supports these purposes.

& n.5 (1981) (*citing Prudential Ins. Co. v. Benjamin*, 328 U.S. 408 (1946) (emphases added)).

The Ninth Circuit's decision not only ignores all of the above statutory and case authorities, it effectively creates a federal system for redressing alleged violations in the business of insurance in direct opposition to the main purpose of the McCarran-Ferguson Act, which was to leave the regulation of the business of insurance to the states. Indeed, the Ninth Circuit's decision effectively turns the clock back to *South-Eastern Underwriters*, which applied general federal laws (there the antitrust laws), to the business of insurance. Thereby the Ninth Circuit's decision, and the "direct-conflict" test which is essential to that decision, defeat the clear purposes of the McCarran-Ferguson Act because they permit precisely that which Congress intended to preclude: the application of a general federal statute, RICO here, to the business of insurance.

II.

THE "DIRECT-CONFLICT" TEST THREATENS TO IMPAIR OR SUPERSEDE A LARGE NUMBER OF STATE LAWS SPECIFICALLY ENACTED TO REGULATE THE BUSINESS OF INSURANCE.

The McCarran-Ferguson Act bars the application of general federal laws if the application of such laws will "invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . ." 15 U.S.C. § 1012(b).[6] A survey of state insurance laws reveals that no fewer than forty-one states have taken seriously the McCarran-

6. A general federal law is one which does not "specifically relate[] to the business of insurance." 15 U.S.C. § 1012(b). This Court addressed the meaning of that phrase in *Barnett Bank, N.A. v. Nelson*, 517 U.S. 25 (1996), and gave it its ordinary meaning.

Ferguson Act's invitation to regulate the business of insurance, and have expressly enacted legislation for that purpose in direct response to the McCarran-Ferguson Act. *See* Appendix C to this brief. For instance, Nevada, the state whose laws are directly at issue here, has legislated as follows:

> The purpose of NRS 686A.010 to 686A.310, inclusive, is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress approved March 9, 1945, being c. 20, 59 Stat. 33, also designated as 15 U.S.C. §§ 1011 to 1015, inclusive, by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Nev. Rev. Stat. § 686A.010 (1997). Nevada's statute unambiguously sets forth the intention and purpose of the Nevada legislature to define, provide for the determination of, and prohibit *all* trade practices which constitute unfair methods of competition or unfair or deceptive acts or practices in the business of insurance. Like most other states, Nevada has undertaken a comprehensive regulation of *all* unfair and deceptive acts and acts of misrepresentation in the business of insurance. *See* Nev. Rev. Stat. §§ 686A.010 to 686A.310.

In addition to the above all-inclusive statement of purpose, forty-eight states have enacted laws specifically forbidding the making, issuing, circulating, publishing, dissemination, or the placing before the public in any manner any false statement or representation with respect to the business of insurance. *See* Appendix D to this brief. Again, Nevada's laws are illustrative of the laws of the other states.

> A person shall not make, issue, circulate or cause to be made, issued or circulated, any . . . statement, . . . which:
>
> 1. Misrepresents the benefits, advantages, conditions or terms of any insurance policy; . . .
>
> 5. Uses any name or title of any policy or class of insurance policies misrepresenting the true nature thereof; . . . .

Nev. Rev. Stat. § 686A.030 (1997).

> No person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a . . . publication, or in the form of a notice, circular, pamphlet, . . . or in any other way, any advertisement, announcement or statement containing any . . . representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

Nev. Rev. Stat. § 686A.040 (1997).

The above statutes, and like statutes enacted by almost all other states, should place beyond question that Nevada and the other states have adopted comprehensive laws for the purpose of regulating misrepresentations and unfair practices in the business of insurance, and that such statutes regulate the alleged conduct at issue in this case. And, it should be beyond argument that application of RICO to the conduct in question will, even under the Ninth Circuit's erroneous analysis, create parallel

systems of law for redressing alleged wrongdoing with respect to insurance policies: (1) the state systems enacted pursuant to the invitation of Congress as set forth in the McCarran-Ferguson Act; and (2) the federal RICO system — which does not specifically relate to the business of insurance. Can anyone doubt that given the choice between RICO remedies on the one hand, and state remedies on the other (which are most often administrative investigation and action by the state insurance commissioner), plaintiffs will rarely, if ever, choose the state system in preference to RICO?

> Most aggrieved insureds would opt for the prospect of treble damages rather than participate in remedial measures structured by the [Insurance Commissioner]. This would make insurers less willing to agree with the [Insurance Commissioner] to settle disputes over alleged violations for fear of compromising their positions in pending or threatened RICO litigation. The ability to act promptly and to secure for insureds settlements is central to the state's ability to protect insureds and to regulate the insured-insurer relationship. The prospect of treble damages and attorneys fees would weaken, diminish and do serious injury to, if not nullify, the sections of [the Insurance Act], and the enforcement mechanisms which protect and regulate that relationship.
>
> Application of RICO would also supersede the state laws at issue. Because RICO provides for a private cause of action and treble damages, and because these provisions of RICO differ dramatically from the way in which [the] insurance code addresses the same conduct, RICO would in effect replace [the Insurance Act] as the principal means by which

> to remedy such conduct. It would convert a system of public redress into a system of private redress. The forum for redress would shift from the [Insurance Commissioner] to the federal courts. The result of these effects would be that RICO would supersede [state] laws.

Ambrose v. Blue Cross & Blue Shield, 891 F. Supp. 1153, 1165 (E.D. Va. 1995), *aff'd*, 95 F.3d 41 (4th Cir. 1996). The provision of two parallel systems with widely disparate remedies for redress of alleged violations in the business of insurance will unquestionably result in aggrieved insureds opting for the more individually profitable system — RICO here — over the potentially less individually profitable, the state administrative remedies which balance the interests of the individual policyholder with the interests of all policyholders, thereby rendering the state systems superfluous and superseded by RICO. Indeed, it will take little ingenuity to cast virtually every dispute between an insured and his or her insurer in terms which will enable application of RICO and the attendant superseding of applicable state statutes. The McCarran-Ferguson Act forbids such a result, even by the acknowledgment of those courts which have embraced the "direct-conflict" test. Accordingly, this Court should hold that application of RICO to the business of insurance impermissibly impairs or supersedes the states' insurance statutes and is barred by the McCarran-Ferguson Act.

III.

UNDER THE "DIRECT-CONFLICT" TEST, INSURERS WILL NO LONGER BE ABLE TO RELY UPON THE APPROVALS OF STATE INSURANCE DEPARTMENTS BUT, INSTEAD, WILL HAVE TO STRUCTURE THEIR POLICIES, PREMIUM RATES AND PRACTICES TO CONFORM TO THE DIFFERENT STANDARDS AND RISKS OF RICO.

Typically, insurers must file policy forms and premium rates they propose to use in a given state with the state's insurance commissioner. At least forty-three states have such statutes in their insurance codes. *See* Appendices A and B to this brief. Nevada's laws state as follows:

> Every authorized insurer . . . shall file with the commissioner all . . . [r]ates and proposed increases thereto; . . . [and] Forms of policies to which the rates apply. . . .

Nev. Rev. Stat. § 686B.070 (1997). And, "[i]f the commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050, he shall disapprove the proposal." Nev. Rev. Stat. § 686B.110.1 (1997). Other states are more direct and decree that

> No basic insurance policy [form] . . . shall be delivered or issued for delivery in this state unless the form has been filed with, and approved by, the commissioner.

Ala. Code § 27-14-8(a) (1997).

The approval by a state's insurance commissioner of an insurer's policy forms and premium rates gives the insurer a

substantial measure of protection that it may market policies conforming to the approved forms and rates without fear of ancillary litigation.[7] Indeed, because states have a strong interest in protecting their citizens, a state insurance commissioner's approval of policy forms, premium rates, or other practices to the extent they are regulated by state law, should be taken as a conclusive determination by the state that the policies, rates or practices in question benefit the state's consumers of insurance products, and are valid policies, rates or practices. Any complaint regarding the approved policies, rates or practices should then be directed to the state's insurance department, the agency specifically delegated such authority by the state's legislature under the state's comprehensive insurance regulatory scheme.[8]

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7. Federal and state doctrines, such as the filed-rate doctrine, the primary jurisdiction doctrine and the exhaustion of remedies doctrine, reflect federal and state policy that approval by regulatory authorities should insulate the regulated industry from claims which challenge approved rates and practices.

8. The proponents of the "direct-conflict" test contend that application of RICO will not invalidate, impair or supersede any state insurance laws because RICO remedies are simply additional to the remedies provided by state insurance laws. This argument assumes that the states have no interest in maintaining the solvency and financial health of insurance companies. States, such as Nevada, however, have an abiding and substantial interest in ensuring that the financial health of insurance companies is not impaired, and that insurers, even if only in rare cases, are not driven into receivership or liquidation. States must balance the interests of individual policyholders (or a class of policyholders) with the interests of all policyholders. *See, e.g.*, Nev. Rev. Stats. § 680A.120 (establishing minimum capital and surplus requirements); § 680A.140 (requiring deposit in state of amount not less than minimum required capital or surplus); § 680A.270 (requiring filing of annual financial statements by insurers); § 679B.230 (empowering insurance commissioner to examine financial condition of insurers); § 680A.190 (authorizing commissioner to suspend or revoke insurer's license for failure to cure impairment of capital or surplus). The "direct-conflict" test impedes

(Cont'd)

The Ninth Circuit's decision, however, overturns this system, which has not only been in place for at least the past fifty years, but also has worked reasonably well until the recent "direct-conflict" decisions of the Ninth Circuit and some other Courts of Appeals have opened the federal door by improperly permitting RICO actions based on alleged wrongdoings with respect to insurance policies. As demonstrated above, an aggrieved insured who is given the choice between a RICO lawsuit and administrative measures by the state insurance commissioner, will almost always choose RICO because it offers potentially far greater individual returns than the typical state insurance statute.

Insurers, such as the CCIA's members, will have to accommodate themselves to this new situation. As observed previously, such accommodation will be manifested by a far lower degree of willingness among insurers to agree with an insurance commissioner to settle disputes over alleged violations of insurance laws for fear of compromising their positions in pending or threatened RICO litigation. *Ambrose, supra.* Correspondingly, state insurance departments will play less of a role in resolving disputes with respect to the business of insurance, and federal courts adjudicating RICO claims will become paramount. Instead of state insurance departments being the initial, if not the final, arbiters of alleged insurance code violations, federal judges and juries will now decide whether

(Cont'd)
the fulfillment of this state interest by creating new and costly liabilities under RICO, and thereby undermines the state's policy choices. States have chosen not to provide broad private rights of action for violations of state unfair insurance practices laws; they have not provided for automatic multiplication of damages, or for the payment of attorneys' fees. Instead, they have most commonly provided for administrative remedies effected by the insurance commissioners. Under such circumstances, the application of RICO and the provision of RICO damages undermines the states' interest of protecting its citizen policyholders by ensuring that insurers remain financially sound.

the conduct of insurers violates RICO, regardless of whether that conduct was previously approved or regulated by the state. Moreover, insurance department approvals will carry little meaning and will provide little protection, if any, to insurers in light of the enormous new RICO liabilities opened up by the "direct-conflict" test. The fulcrum of insurance regulation will shift from the states to federal courts adjudicating RICO claims.

Insurers, who have hitherto relied upon state insurance department approvals for their policies, rates and regulated practices will have to restructure their policies, premium rates and other practices to conform to RICO standards and the new risks presented by the newly-developed liabilities. Thereby, additional state insurance statutes will be impaired or superseded and the business of insurance will come to be regulated, not by the states as the McCarran-Ferguson Act had decreed, but by the shifting decisions of federal judges and juries across the land. As demonstrated above, and by the Petitioners' Brief, such a result is not even remotely supported by the express language of the Act, its stated purposes and its legislative history.

CONCLUSION

Petitioners' Brief demonstrates that the "direct-conflict" test ignores the express terms of the McCarran-Ferguson Act (and introduces terms into the Act which Congress did not include therein); it ignores Congress's intent and purpose; it undermines the states' policy choices; and it misapplies preemption analysis despite Congress's clear enactments that insurance regulation will be left to the states unless Congress enacts a law which specifically relates to the business of insurance. This brief adds that the "direct-conflict" test will impair or supersede an enormous number of state insurance statutes, such as the states' unfair insurance practices laws, and policy form and rate approval laws. In addition, application of RICO to conduct

concerning the business of insurance severely impedes realization of the purposes of the McCarran-Ferguson Act, as set forth in the Act itself. Any one of these reasons would be independently sufficient to reject the "direct-conflict" test; collectively, they compel the rejection of that test in the context of the McCarran-Ferguson Act. This Court should clarify that operation of the McCarran-Ferguson Act *is not limited to a "direct conflict"* between application of a general federal statute and a state statute, the purpose of which is the regulation of the business of insurance, and that the Act bars the application of the federal RICO statute to conduct regulated by state statutes enacted for the purpose of regulating the business of insurance.

Respectfully submitted,

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APPENDIX

APPENDIX A — SURVEY OF STATE STATUTES REQUIRING THE FILING AND APPROVAL OF POLICY FORMS

STATE	STATUTE	TEXT
Alabama	Ala. Code § 27-14-8(a)	No basic insurance policy . . . shall be delivered or issued for delivery in this state unless the form has been filed with, and approved by, the commissioner.
Alabama	Ala. Code § 27-14-9	The commissioner may disapprove any form filed under section 27-14-8 or withdraw any previous approval thereof . . .
Alaska	Alaska Stat. § 21.42.120(a)	A basic insurance policy . . . may not be delivered, or issued for delivery in this state, unless the form has been filed with and approved by the director.
Alaska	Alaska Stat. § 21.42.130	The director shall disapprove a form filed under AS 21.42.120 or withdraw a previous approval of the form . . .

STATE	STATUTE	TEXT
Arizona	Ariz. Rev. Stat. Ann. § 20-1111 A.	The director shall disapprove any form of policy, application, rider or endorsement or withdraw any previous approval thereof . . .
Arkansas	Ark. Code Ann. § 23-79-109(a)	No basic insurance policy . . . shall be issued, delivered, or used as to a subject of insurance resident, located, or to be performed in this state unless the form has been filed with and approved by the commissioner . . .
Arkansas	Ark. Code Ann. § 23-79-110(a)	The commissioner shall disapprove any form filed under § 23-79-109, or withdraw any previous approval . . .
Delaware	Del. Code Ann. tit. 18 § 2712(a)	No basic insurance policy . . . shall be delivered or issued for delivery in this State, unless the form has been filed with the Commissioner.

STATE	STATUTE	TEXT
Delaware	Del. Code Ann. tit. 18 § 2713	The Commissioner shall disapprove any form filed under § 2712 of this title, or withdraw any previous effectiveness thereof . . .
District of Columbia	D.C. Code Ann. § 35-1531	The Commissioner may require that all policy forms used by every company covering risks in the District be filed with the Commissioner.
Florida	Fla. Stat. Ann. § 627.410(1)	No basic insurance policy . . . shall be delivered or issued for delivery in this state, unless the form has been filed with the department . . . and has been approved by the department.
Florida	Fla. Stat. Ann. § 627.411(1)	The department shall disapprove any form filed under § 627.410, or withdraw any previous approval thereof, . . .

STATE	STATUTE	TEXT
Georgia	Ga. Code Ann. § 33-24-9(a)	No basic insurance policy . . . shall be delivered or issued for delivery in this state unless the form has been filed with and approved by the Commissioner.
Georgia	Ga. Code Ann. § 33-24-10	The Commissioner shall disapprove any form filed under Code Section 33-24-9 or withdraw any previous approval of such form . . .
Idaho	Idaho Code § 41-1812(1)	No basic insurance policy . . . shall be delivered, or issued for delivery in this state, unless the form has been filed with the director.
Idaho	Idaho Code § 41-1813	The director shall disapprove any form filed under section 41-1812, or withdraw any previous approval thereof, . . .

STATE	STATUTE	TEXT
Illinois	215 Ill. Comp. Stat. Ann. 5/143 (2)	. . . The Director shall require the filing of all policy forms issued or delivered by any company . . .
Illinois	215 Ill. Comp. Stat. Ann. 5/143 (2)	. . . If the Director shall find from an examination of any such policy form . . . that it (i) violates any provision of this Code, (ii) contains inconsistent, ambiguous, or misleading clauses, or (iii) contains exceptions and conditions that will unreasonably or deceptively affect the risks that are purported to be assumed by the policy, he shall order the company or companies issuing these forms to discontinue their use.
Indiana	Ind. Code Ann. § 244.5-4-203 (2)	. . . [A]ll policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders relating to consumer

STATE	STATUTE	TEXT
		credit insurance delivered or issued for delivery in this state . . . shall be filed by the insurer with the insurance commissioner.
Indiana	Ind. Code Ann. § 244.5-4-203 (1)	A creditor may not use a form . . . the filing of which is required by this section, if the insurance commissioner has disapproved the form or schedule and has notified the insurer of his disapproval.
Iowa	Iowa Code Ann. § 515.109 1.	The form of all policies . . . issued or proposed to be issued by any insurance company doing business in this state under the provisions of this chapter, shall first be examined and approved by the commissioner of insurance.

STATE	STATUTE	TEXT
Kansas	Kan. Stat. Ann. § 40-216	. . . No contract of insurance or indemnity shall be issued or delivered in this state until the form of the same has been filed with the commissioner of insurance . . .
Kentucky	Ky. Rev. Stat. Ann. § 304.14-120(1)	No basic insurance policy . . . shall be delivered, or issued for delivery in this state, unless the form has been filed with and approved by the commissioner.
Kentucky	Ky. Rev. Stat. Ann. § 304.14-130(1)	The commissioner shall disapprove any form filed under KRS 304.14-120, or withdraw any previous approval thereof . . .
Louisiana	La. Rev. Stat. Ann. § 22:620 A.	No basic insurance policy form . . . shall be issued, delivered, or used unless it has been filed with and approved by the commissioner of insurance.

STATE	STATUTE	TEXT
Louisiana	La. Rev. Stat. Ann. § 22:621	The commissioner of insurance shall disapprove any such form of policy, application, rider, or endorsement, or withdraw any previous approval thereof, . . .
Maine	Me. Rev. Stat. Ann. tit. 24-A § 2412 1.	An insurance policy . . . may not be delivered or issued for delivery in this State unless the form has been filed with and approved by the superintendent.
Maine	Me. Rev. Stat. Ann. tit. 24-A § 2413 1.	The superintendent shall disapprove any form filed under section 2412, or withdraw any previous approval thereof . . .
Maryland	Md. Code Ann., Ins. § 11-206 (a)(1)	Except as otherwise provided in this section, each insurer shall file with the Commissioner all . . . policy forms, and endorsements that the insurer proposes to use.

STATE	STATUTE	TEXT
Maryland	Md. Code Ann., Ins. § 11-206 (g)(3)	A filing is deemed approved unless disapproved by the Commissioner . . . .
Massachusetts	Mass. Gen. Laws Ann. ch. 175 § 111A	. . . No such policy shall be issued or delivered until a copy of the form thereof has been on file for thirty days with the commissioner, unless before the expiration of said thirty days he shall have approved the form of the policy in writing. . . .
Massachusetts	Mass. Gen. Laws Ann. ch. 175 § 193H	The commissioner may at any time give notice to the insurer of his intention to withdraw his approval of any form. . . .
Michigan	Mich. Comp. Laws Ann. § 500.2236(1)	A basic insurance policy form . . . shall not be issued or delivered to a person in this state . . . until a copy of the form is filed with the insurance bureau and approved by the commissioner . . .

STATE	STATUTE	TEXT
Michigan	Mich. Comp. Laws Ann. § 500.2236 (5)	Upon written notice to the insurer, the commissioner may disapprove, withdraw approval or prohibit the issuance . . . of any form . . . of the policy.
Minnesota	Minn. Stat. Ann. § 72C.10 Subd. 1.	No insurer shall make, issue, amend, or renew any policy or contract . . .unless the contract is in compliance with the requirements of sections 72C.06 to 72C.09 and unless the contract is filed with the commissioner for approval.
Mississippi	Miss. Code Ann. § 83-2-7(1)	Except as provided in § 83-2-9 and subsection (2) of this section, every insurer shall file with the commissioner all . . . policy forms and endorsements at least thirty (30) days prior to the proposed effective date which shall be stated in the filing.

STATE	STATUTE	TEXT
Mississippi	Miss. Code Ann. § 83-2-11(1)	The commissioner shall disapprove a . . . policy form or endorsement if the commissioner finds that the . . . policy form or endorsement . . . :
Montana	Mont. Code Ann. § 33-1-501(1)(a)	An insurance policy . . . may not be delivered or issued for delivery in Montana unless the form has been filed with and approved by the commissioner . . .
Montana	Mont. Code Ann. § 33-1-502	The commissioner shall disapprove any form filed under 33-1-501 or withdraw any previous approval thereof . . .
Nebraska	Neb. Rev. Stat. § 44-5020(2)(a)	. . . [A]n insurer shall file all forms and any related attachment rules with the director prior to use.

STATE	STATUTE	TEXT
Nebraska	Neb. Rev. Stat. § 44-5021 (1)	If . . . the director finds that a filing does not meet the requirements of the Property and Casualty Insurance Rate and Form Act, he or she shall send written notice of disapproval . . .
Nevada	Nev. Rev. Stat. § 686B.070	Every authorized insurer . . . shall file with the commissioner all: . . . 2. Forms of policies to which the rates apply . . .
New Jersey	N.J. Stat. Ann. § 17:29AA-6	. . . [I]nsurers shall file copies of all policy forms for approval with the commissioner at least 30 days prior to becoming effective.
New Jersey	N.J. Stat. Ann. § 17:29AA-13	If the commissioner finds, after a hearing, that a . . . policy form in effect for any . . . insurer . . . is not in compliance with the standards of this act, he shall

STATE	STATUTE	TEXT
		issue an order specifying in what respects it so fails, and stating when . . . such . . . form shall be deemed no longer effective.
New Mexico	N.M. Stat. Ann. § 59A-18-12 A.	No insurance policy . . . shall be delivered or issued for delivery in this state . . . until a copy of the form and the classification of risks pertaining thereto have been filed with the superintendent.
New Mexico	N.M. Stat. Ann. § 59A-18-14 A.	The superintendent shall review any filing made pursuant to Section 59A-18-12 . . . within sixty days of the filing date. The superintendent shall . . . disapprove any form or rate . . .
New York	N.Y. Ins. Law § 2307(b)	No policy form shall be delivered or issued for delivery unless it has been filed with the superintendent and . . . he has approved it . . .

STATE	STATUTE	TEXT
New York	N.Y. Ins. Law § 2311(a)	Under such rules and regulations as he shall adopt, the superintendent may, by order, suspend or modify the requirements of filing as to any kind of insurance, subdivision or combination thereof . . . before they are used.
North Carolina	N.C. Gen. Stat. § 58-38-30(a)	No insurer may make, issue, amend, or renew any insurance policy . . . unless the policy is filed with the Commissioner for his approval.
North Carolina	N.C. Gen. Stat. § 58-51-95(c)	The Commissioner may . . . disapprove such form . . .
North Dakota	N.D. Cent. Code § 26.1-30-19 1.	No insurance policy . . . may be issued or delivered in this state until the form of that policy . . . has been filed with and approved by the commissioner.

STATE	STATUTE	TEXT
North Dakota	N.D. Cent. Code § 26.1-30-21 1.	If the commissioner disapproves any form, the commissioner shall notify the company or organization which filed the form . . . and provide written notice of disapproval . . .
Ohio	Ohio Rev. Code Ann. § 3935.04 (A)	Every insurer shall file with the superintendent of insurance . . . every form of policy, endorsement, rider, manual . . . which it proposes to use.
Ohio	Ohio Rev. Code Ann. § 3935.05 (A)	If . . . the superintendent of insurance finds that a filing does not meet the requirements of section 3935.01 to 3935.17 of the Revised Code, he shall send to the insurer . . . written notice of disapproval of the filing. . . .
Oklahoma	Okla. Stat. Ann. tit. 36 § 3610 A.	No insurance policy form . . . shall be issued, delivered, or used unless filed with and approved by the Insurance Commissioner.

STATE	STATUTE	TEXT
Oklahoma	Okla. Stat. Ann. tit. 36 § 3611 A.	The Insurance Commissioner shall disapprove any form of policy, application, rider or endorsement or withdraw any previous approval thereof . . .
Oregon	Or. Rev. Stat. § 742.003(1)	Except where otherwise provided by law, no basic policy form . . . shall be delivered or issued for delivery in this state until the form has been filed with and approved by the Director of the Department of Consumer and Business Services.
Oregon	Or. Rev. Stat. § 742.005	The Director of the Department of Consumer and Business Services shall disapprove any form requiring the director's approval: (1) If the director finds it does not comply with the law; . . . (2) If the director finds it contains any provision . . . likely to mislead a person. . . .

STATE	STATUTE	TEXT
Pennsylvania	Penn. Stat. Ann. tit. 40 § 477b	It shall be unlawful for any insurance company . . . doing business in this Commonwealth, to issue, sell, or dispose of any policy, contract, or certificate, covering . . . all forms of casualty insurance . . . or any other contract of insurance . . . in connection therewith, until the forms of the same have been submitted to and formally approved by the Insurance Commissioner . . .
Pennsylvania	Penn. Stat. Ann. tit. 40 § 477b	Such approval shall become void upon any subsequent notice of disapproval from the Insurance Commissioner . . .
South Carolina	S.C. Code Ann. § 38-61-20 (A)	It is unlawful for an insurer doing business in this State to issue or sell in this State any policy, contract, or certificate until it has been filed with and approved by the director or his designee.

STATE	STATUTE	TEXT
South Carolina	S.C. Code Ann. § 38-61-20 (A)	. . . The director or his designee may disapprove the form . . .
South Dakota	S.D. Codified Laws § 58-11-12	No basic insurance policy . . . shall be delivered or issued for delivery in this state, unless the form has been filed with and approved by the director . . .
South Dakota	S.D. Codified Laws § 58-11-21	The director shall disapprove any form filed under § 58-11-12, or withdraw any previous approval thereof . . .
Tennessee	Tenn. Code Ann. § 56-5-305(a)	Every insurer of personal risk insurance shall file with the commissioner all . . . policy forms, and endorsements at least thirty (30) days before the proposed effective date.
Tennessee	Tenn. Code Ann. § 56-5-305(d)(1)	A filing shall be deemed to meet the requirements of this part and to become effective unless disapproved by the commissioner . . . .

STATE	STATUTE	TEXT
Texas	Tex. Ins. Code Ann. § 5.15 (a)	Every insurer shall file with the Board . . . the policies and endorsement forms proposed to be used, and the information upon which the insurer supports the filing.
Texas	Tex. Ins. Code Ann. § 5.15 (b)	Any filing made pursuant to this article shall be approved by the Board unless it finds that such filing does not meet the requirements of this subchapter. . . . [A]fter the filing has been made the Board shall in writing approve or disapprove the same . . .
Utah	Utah Code Ann. § 31A-21-201(1)	No form . . . may be used, sold, or offered for sale unless it has been filed with the commissioner.
Utah	Utah Code Ann. § 31A-21-201(3)(a)	The commissioner may disapprove a form at any time upon a finding that . . .

STATE	STATUTE	TEXT
Vermont	Vt. Stat. Ann. tit. 8 § 3541(a)	No basic insurance policy . . . shall be delivered, or issued for delivery in this state, unless the form has been filed with and approved by the commissioner.
Vermont	Vt. Stat. Ann. tit. 8 § 3542	The commissioner shall disapprove any form filed under this subchapter or withdraw any previous approval thereof, . . .
Virginia	Va. Code Ann. § 38.2-317 A.	No insurance policy or endorsement . . . shall be delivered or issued for delivery in this Commonwealth unless the policy form or endorsement is filed with the Commissioner . . .
Virginia	Va. Code Ann. § 38.2-317 B.	The Commissioner may disapprove or withdraw approval of the policy form or endorsement. . . .
Washington	Wash. Rev. Code Ann. § 48.18.100(1)	No insurance policy . . . shall be issued, delivered, or used unless it has been filed with and approved by the commissioner. . . .

STATE	STATUTE	TEXT
Washington	Wash. Rev. Code Ann. § 48.18.110(1)	The commissioner shall disapprove any such form of policy, application, rider, or endorsement, or withdraw any previous approval thereof, only.
West Virginia	W. Va. Code § 33-6-8 (a)	Except as provided in section eight, article seventeen of this chapter (fire and marine forms), no insurance policy form . . . shall be delivered or issued for delivery in this state by an insurer unless it has been filed with and approved by the commissioner . . .
West Virginia	W. Va. Code § 33-6-9	The commissioner shall disapprove any such form of policy, application, rider, or endorsement or withdraw any previous approval thereof . . .
Wisconsin	Wis. Stat. Ann. § 631.20(1)	. . . No form subject to s. 631.01(1), except as exempted under s. 631.01(2) to (5), may be used unless it has been filed with and approved by the commissioner.

STATE	STATUTE	TEXT
Wisconsin	Wis. Stat. Ann. § 631.20(2)	. . . The commissioner may disapprove a form upon a finding . . .
Wyoming	Wyo. Stat. Ann. § 26-15-110(a)	No basic insurance policy . . . shall be delivered or issued for delivery in this state unless the form is filed with and approved by the commissioner.
Wyoming	Wyo. Stat. Ann. § 26-15-111(a)	The commissioner . . . shall disapprove any form filed under W.S. 26-15-110, or withdraw any previous approval thereof . . .

APPENDIX B — SURVEY OF STATE STATUTES REQUIRING THE FILING AND APPROVAL OF PREMIUM RATES

STATE	STATUTE	TEXT
Alabama	Ala. Code § 27-13-29	. . . [E]very insurer shall, before using or applying any rate to any kind of insurance coming within the scope of this article, file with the department a copy of the rating system upon which such rate is based or by which such rate is fixed or determined.
Alabama	Ala. Code § 27-13-30	If . . . the commissioner shall find that such rating systems . . . result in or produce rates that are unreasonably high or excessive, or are not adequate for the safeness and soundness of the insurer or are unfairly discriminatory between risks in this state involving essentially the same hazards, he shall issue an order . . . directing that such rating systems be altered in the manner, and to the extent, stated in such order to produce rates that are reasonable and adequate and not unfairly discriminatory.

STATE	STATUTE	TEXT
Alaska	Alaska Stat. § 21.39.040(a)	Each insurer shall file with the director . . . every manual, minimum, class rate, rating schedule, or rating plan and every other rating rule, and each modification of any of them that it proposes to use.
Alaska	Alaska Stat. § 21.39.040(f)	The director may . . . suspend or modify the requirement of filing on a kind of insurance, subdivision or combination of them, or on classes of risks, the rates for which . . . the filing and approval of which are, in the director's opinion, not desirable or necessary for the protection of the public.
Arizona	Ariz. Rev. Stat. Ann. § 20-357A.	Every insurer shall file with the director the rating systems which it proposes to use. . . . [T]he term "rating systems" includes every manual of classifications, rules and rates, every rating plan, and every modification of any of the foregoing.

STATE	STATUTE	TEXT
Arizona	Ariz. Rev. Stat. Ann. § 20-388	If the director finds that a rate is not in compliance with Section 20-383, the director shall issue an order specifying in what respects it so fails and stating that, within thirty days after the order is issued, the rate is no longer effective.
Arkansas	Ark. Code Ann. § 23-67-211	(a) . . . (1) In a competitive market, every insurer shall file with the commissioner all rates, supplementary rate information, and supporting information for risks which are to be written in this state. (b) . . . In a noncompetitive market, every insurer shall file with the commissioner all rates for that market.
Arkansas	Ark. Code Ann. § 23-67-213	(1) The commissioner may disapprove a rate without a hearing if the insurer fails to file the information required pursuant to this chapter.

STATE	STATUTE	TEXT
		(2) The commissioner may disapprove a rate without a hearing . . .
California	Cal. Ins. Code § 1861.05(B)	Every insurer . . . shall file a complete rate application with the commissioner.
Colorado	Colo. Rev. Stat. Ann. § 10-4-405(1)	. . . [E]very insurer shall file with the commissioner every manual of classifications, rules, and rates, every rating plan, and every modification of any of the foregoing which it proposes to use in this state.
Colorado	Colo. Rev. Stat. Ann. § 10-4-406(1)	Upon receipt of filings required under the provisions of section 10-4-405(1), the commissioner shall review, or cause to be reviewed, the same . . . in order to determine whether they meet the requirements of this part 4.

STATE	STATUTE	TEXT
Connecticut	Conn. Gen. Stat. Ann. § 38a-688(a)	The following procedures shall apply with respect to rates pertaining to personal risk insurance and residual markets: (1) In a competitive market, every insurer shall file with the commissioner all rates . . . to be used in this state, provided that such rates and information need not be filed for inland marine risks which by general custom of the business are not written according to manual rules or rating plans. (2) In a noncompetitive market, every insurer shall file with the commissioner all rates . . . for that market and such supporting information as is required by the commissioner. . . .

STATE	STATUTE	TEXT
Connecticut	Conn. Gen. Stat. Ann. § 38a-688(b)(2)	The commissioner may disapprove a rate if the insurer fails to comply with the filing requirements of this section.
Delaware	Del. Code Ann. tit. 18 § 2504(a)	Every insurer shall file with the Commissioner, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual, minimum, class rate, rating schedule or rating plan . . . which it proposes to use.
Delaware	Del. Code Ann. tit. 18 § 2506(a)	The Commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter. The filings shall be deemed to meet the requirements of this chapter unless disapproved by the Commissioner . . .

STATE	STATUTE	TEXT
District D.C. of Columbia	Code Ann. § 35-1704(a)	. . . [E]very company shall file with the Commissioner . . . except as to rates on inland marine risks which are not made by a rating organization and which by general custom of the business are not written according to manual rates or rating plans, all rates and rating plans, rules, and classifications which it uses or proposes to use in the District.
Florida	Fla. Stat. Ann. § 627.062 (2)(a)	Insurers . . . shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on such classes of insurance written in this state. A copy of rates . . . shall be filed with the department . . .

STATE	STATUTE	TEXT
Florida	Fla. Stat. Ann. § 627.062 (2)(g)	The department may at any time review a rate, rating schedule, rating manual, or rate change; . . . If the department finds . . . that a rate may be excessive, inadequate, or unfairly discriminatory, the department shall . . . disapprove the rate and shall so notify the insurer. . . .
Georgia	Ga. Code Ann. § 33-9-21	(a) Every insurer shall maintain with the Commissioner copies of the rates, rating plans, rating systems, underwriting rules, and policy or bond forms used by it . . . (d) Any domestic, foreign, or alien insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule at least 45 days prior to any indicated effective date for all insurance . . .

STATE	STATUTE	TEXT
Georgia	Ga. Code Ann. § 33-9-23(a)	The Commissioner may, at any reasonable time, make or cause to be made an examination of every admitted insurer transacting any class of insurance to which this chapter is applicable to ascertain whether the insurer and every rate and rating system used by it for each class of insurance complies with the requirements and standards of this chapter applicable thereto.
Hawaii	Haw. Rev. Stat. Ann. § 431:14-104(a)	Every insurer shall file . . . with the commissioner, except as to specific inland marine risks which by general custom of the business are not written according to manual rate or rating plans, every manual of classifications, rules, and rates, every rating plan, and every other rating rule . . . which it proposes to use.

STATE	STATUTE	TEXT
Hawaii	Haw. Rev. Stat. Ann. § 431:14-106(a)	If . . . the commissioner finds that a filing does not meet the requirements of this article, the commissioner shall send . . . written notice of disapproval of the filing . . .
Illinois	215 Ill. Comp. Stat. Ann. 5/488.1	. . . The Director may require submission of copies of the rates, rating schedules and rating manuals of a company as he deems necessary and proper.
Indiana	Ind. Code Ann. § 27-1-22-4(a)	Every insurer shall file with the commissioner, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual of classifications, rules, and rates, every rating schedule, every rating plan . . . which it proposes to use.

STATE	STATUTE	TEXT
Indiana	Ind. Code Ann. § 27-1-22-5(a)	. . . [T]he commissioner, if he shall have reason to believe that any filing is not in compliance with the applicable provisions of section 3 of this chapter, or in the case of an alleged violation of section 6 of the chapter if he finds on the basis of the information on file with the department that there has been a prima facie showing of a violation of that section, shall hold a hearing upon not less than ten (10) days written notice to the rating organization or insurer which made the filing in issue, specifying the items and matters to be considered and stating in what manner and to what extent noncompliance is alleged to exist.
Iowa	Iowa Code Ann. § 515F.5 1.	An insurer shall file with the commissioner, except as to inland marine risks which are not written according to

STATE	STATUTE	TEXT
		manual rates or rating plans, every manual, minimum premium, class rate, rating schedule, rating plan . . . which it proposes to use.
Iowa	Iowa Code Ann. § 515F.6 1.	If . . . the commissioner finds that a filing does not meet the requirements of this chapter, written notice of disapproval shall be sent to the insurer or advisory organization which made the filing . . .
Kentucky	Ky. Rev. Stat. Ann. § 304.13-051	(1) In a competitive market, every insurer shall file with the commissioner rates and supplementary information to be used in this state for commercial risks as designated by the commissioner and for all personal risks.

STATE	STATUTE	TEXT
		(2) In a noncompetitive market, every insurer shall file with the commissioner all rates for that market, supplementary rate information, and supporting information at least thirty (30) days before the proposed effective date of the rates.
Kentucky	Ky. Rev. Stat. Ann. § 304.13-071(1)	Existing rates in a noncompetitive market may be disapproved . . .
Louisiana	La. Rev. Stat. Ann. § 22:1407 A.(1)	Every insurer whose rates are subject to regulation under the provisions of this Part shall file with the respective divisions . . . every manual, minimum, class rate, rating schedule or rating plan . . . which it proposes to use.

STATE	STATUTE	TEXT
Louisiana	La. Rev. Stat. Ann. § 22:1408 A.	If within the waiting period or any extension thereof as provided in Subsection D of R.S. 22:1407, the respective division finds that a filing does not meet the requirements of this Part, it shall send to the insurer or rating organization which made such filings, written notice of disapproval . . .
Maine	Me. Rev. Stat. Ann. tit. 24-A § 2304-A 1.	Every insurer shall file with the superintendent, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual rate, minimum premium, class rate, rating schedule or rating plan . . . which it proposes to use.

STATE	STATUTE	TEXT
Maine	Me. Rev. Stat. Ann. tit. 24-A § 2306 1.	If at any time the superintendent has reason to believe that a filing does not meet the requirements of this chapter, or violates any of the provisions of chapter 23, the superintendent shall . . . issue an order specifying in what respects the superintendent finds that such filing fails to meet the requirements of this chapter, and stating when . . . such filing shall be deemed no longer effective.
Maryland	Md. Code Ann., Ins. § 11-206 (a)(1)	. . . [E]ach insurer shall file with the Commissioner all rates, supplementary rate information, . . . and all modifications of rates, supplementary rate information, . . . and endorsements that the insurer proposes to use.

STATE	STATUTE	TEXT
Maryland	Md. Code Ann., Ins. § 11-208 (a)	. . . Unless the filer demonstrates that a proposed rate is not excessive, inadequate, or unfairly discriminatory, the Commissioner may disapprove the filing.
Massachusetts	Mass. Gen. Laws Ann. ch. 175A § 6(a)	Every insurer shall file with the commissioner or his designated representative every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use.
Massachusetts	Mass. Gen. Laws Ann. ch. 175A § 7(a)	If at any time the commissioner finds that a filing does not meet the requirements of this chapter, he shall . . . issue an order . . . stating . . . such filing shall be deemed no longer effective.

STATE	STATUTE	TEXT
Michigan	Mich. Comp. Laws Ann. § 500.2606(1)	Every insurer shall file with the commissioner, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual, minimum, class rate, rating schedule or rating plan . . . which it proposes to use.
Michigan	Mich. Comp. Laws Ann. § 500.2616 (1)	If . . . the commissioner finds that a filing does not meet the requirements of this chapter, he shall send to the insurer or rating organization which made such filing, written notice of disapproval of such filing . . .
Minnesota	Minn. Stat. Ann. § 70A.06 Subdiv. 1.	Every licensed insurer . . . shall file with the commissioner all rates and all changes and amendments of rates made by it for use in this state not later than their effective date.

STATE	STATUTE	TEXT
Minnesota	Minn. Stat. Ann. § 70A.11 Subdiv. 1.	. . . If the commissioner finds . . . that a rate is not in compliance with section 70A.04, the commissioner shall order that its use is to be discontinued . . .
Mississippi	Miss. Code Ann. § 83-2-7(1)	Except as provided in § 83-2-9 and subsection (2) of this section, every insurer shall file with the commissioner all rates, supplementary rate information . . . at least thirty (30) days prior to the proposed effective date which shall be stated in the filing.
Mississippi	Miss. Code Ann. § 83-2-11(1)	The commissioner shall disapprove a rate . . . if the commissioner finds that the rate is unjustified . . .
Missouri	Mo. Ann. Stat. § 379.321 1.	Every insurer shall file with the director, except as to inland marine

STATE	STATUTE	TEXT
		risks which by regulation . . . are not written according to manual rates or rating plans, every manual of classifications, rules, underwriting rules and rates, every rating plan and every modification of the foregoing which it uses and . . . to which such rates are applied.
Montana	Mont. Code Ann. § 33-16-203(1)	Every insurer . . . shall file with the commissioner all rates intended for use within this state, together with supporting data sufficient to substantiate such filing.
Montana	Mont. Code Ann. § 33-16-205	If, after examination . . . the commissioner has good cause to believe that . . . any rate, rating plan, or rating system made or used by any such

STATE	STATUTE	TEXT
		insurer or rating organization does not comply with the requirements and standards of this chapter applicable to it, he shall . . . give notice, . . . stating therein in what manner and to what extent such noncompliance is alleged to exist . . .
Nebraska	Neb. Rev. Stat. § 44-5020 (1)(a)	. . . [E]ach insurer shall file with the director every rating system and every modification thereof which it proposes to use.
Nebraska	Neb. Rev. Stat. § 44-5021 (1)	If . . . the director finds that a filing does not meet the requirements of the Property and Casualty Insurance Rate and Form Act, he or she shall send written notice of disapproval . . .

STATE	STATUTE	TEXT
Nevada	Nev. Rev. Stat. § 686B.070	Every authorized insurer . . . shall file with the commissioner all: 1. Rates and proposed increases thereto . . .
Nevada	Nev. Rev. Stat. § 686B.110 1.	. . . If the commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050, he shall disapprove the proposal.
New Hampshire	N.H. Rev. Stat. Ann. § 414:4 II.	For casualty insurance, every insurer shall file with the commissioner every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use.

STATE	STATUTE	TEXT
New Hampshire	N.H. Rev. Stat. Ann. § 414:5 I.	If at any time the commissioner finds that a filing does not meet the requirements of this chapter, he shall disapprove the same.
New Jersey	N.J. Stat. Ann. § 17:29AA-5	. . . [E]very authorized and admitted insurer and every rating organization shall file with the commissioner all rates and supplementary rate information . . . made by it for use in this State not later than 30 days after becoming effective.
New Jersey	N.J. Stat. Ann. § 17:29AA-13	If the commissioner finds, after a hearing, that a rate . . . in effect for any rating organization or insurer . . . is not in compliance with the standards of this act, he shall issue an order specifying in what respects it so fails, and stating when . . . such rate . . . shall be deemed no longer effective.

STATE	STATUTE	TEXT
New Mexico	N.M. Stat. Ann. § 59A-17-9	. . . [E]very insurer or the rate service organization designated by the insurer for filing of rates . . . shall file with the superintendent all rates and supplementary rate information and all changes and amendments thereof made by it for use in this state at least sixty days before they become effective.
New Mexico	N.M. Stat. Ann. § 59A-17-13A.	The superintendent shall within sixty days after the filing of a rate under Section 59A-17-9 . . . disapprove any rate if he finds that it does not comply with those provisions.
New York	N.Y. Ins. Law § 2307(a)	No insurer or rate service organization shall use a rating classification or territory unless it has been filed with the superintendent and either he has

STATE	STATUTE	TEXT
		approved it, or ninety days have elapsed and he has not disapproved it as unfairly discriminatory or violative of public policy.
New York	N.Y. Ins. Law § 2311(a)	Under such rules and regulations as he shall adopt, the superintendent may, by order, suspend or modify the requirements of filing as to any kind of insurance . . .
North Carolina	N.C. Gen. Stat. § 58-41-50(b)	. . . [A]ll rates . . . must be filed with the Commissioner . . . before they may be used in this State.
North Dakota	N.D. Cent. Code § 26.1-25-04 1.	Every insurer shall file with the commissioner, except as to inland marine risks which by general custom of the business are not written according

STATE	STATUTE	TEXT
		to manual rates or rating plans, every manual, minimum class rate, rating schedule or rating plan, and every other rating rule . . . which it proposes to use.
North Dakota	N.D. Cent. Code § 26.1-25-05 1.	If . . . the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall send to the insurer or advisory organization which made the filing written notice of disapproval of the filing . . .
Ohio	Ohio Rev. Code Ann. § 3935.04 (A)	Every insurer shall file with the superintendent of insurance, except as to inland marine risks which by general custom of the business are not written

STATE	STATUTE	TEXT
		according to manual rates or rating plans, every form of a policy . . . minimum class rate, rating schedule, or rating plan, and every other rating rule . . . which it proposes to use.
Ohio	Ohio Rev. Code Ann. § 3935.05 (A)	If . . . the superintendent of insurance finds that a filing does not meet the requirements of section 3935.01 to 3935.17 of the Revised Code, he shall send . . . written notice of disapproval of the filing . . .
Oklahoma	Okla. Stat. Ann. tit. 36 § 903 A.1	. . . [E]very insurer governed by the provisions of this act shall file with the Board . . . all rates and rating plans . . . which it uses or proposes to use in this state except as otherwise provided in this section.

STATE	STATUTE	TEXT
Oklahoma	Okla. Stat. Ann. tit. 36 § 903 L.	If the Board finds that a filing does not meet the requirements of this act, it shall send to the insurer or rating organization which made such filing, written notice of disapproval of such filing . . .
Oregon	Or. Rev. Stat. § 737.205	(1) Every insurer shall file with the Director of the Department of Consumer and Business Services copies of the rates, rating plans and rating systems used by it.
Pennsylvania	Penn. Stat. Ann. tit. 40 § 1184	(a) Every insurer shall file with the commissioner every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use in this Commonwealth.

STATE	STATUTE	TEXT
Pennsylvania	Penn. Stat. Ann. tit. 40 § 1185	(a) Upon the review at any time by the Commissioner of a filing he shall . . . issu[e] an order of disapproval. . . .
Rhode Island	R.I. Gen. Laws § 27-6-8 (a)	Every insurer shall file with the commissioner, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual, minimum, or class rate, rating schedule or rating plan . . . which it proposes to use . . .
Rhode Island	R.I. Gen. Laws § 27-6-17	If . . . the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall send . . . written notice of disapproval . . .

STATE	STATUTE	TEXT
South Carolina	S.C. Code Ann. § 38-73-340	Every insurer shall file with the department . . . every manual, minimum, or class rate, rating schedule, or rating plan . . . which it proposes to use.
South Dakota	S.D. Codified Laws § 58-24-10	Every insurer shall file with the director of the Division of Insurance every manual, minimum, class rate, rating schedule or rating plan . . . which it proposes to use.
South Dakota	S.D. Codified Laws § 58-24-19	If . . . the director finds that a filing does not meet the requirements of this chapter, he shall send . . . written notice of disapproval of such filing . . .

STATE	STATUTE	TEXT
Tennessee	Tenn. Code Ann. § 56-5-305(a)	Every insurer of personal risk insurance shall file with the commissioner all rates, supplementary rate information, . . . and endorsements at least thirty (30) days before the proposed effective date.
Tennessee	Tenn. Code Ann. § 56-5-308 (a)	. . . The commissioner shall disapprove a rate if . . . [t]he commissioner finds that the rate is excessive, inadequate or unfairly discriminatory. . . .
Texas	Tex. Ins. Code Ann. § 5.15 (a)	Every insurer shall file with the Board every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use.
Texas	Tex. Ins. Code Ann. § 5.15 (b)	Any filing made pursuant to this article shall be approved by the Board unless it finds that such filing does not meet the requirements of this subchapter. . . .

STATE	STATUTE	TEXT
		[A]fter the filing has been made the Board shall in writing approve or disapprove the same . . .
Utah	Utah Code Ann. § 31A-19-203(1)(a)	. . . [E]very authorized insurer . . . shall file with the commissioner all rates . . . that are made by it for use in this state.
Utah	Utah Code Ann. § 31A-19-207(1)	If the commissioner finds . . . that a rate is not in compliance with Section 31A-19-201, the commissioner shall order that its use be discontinued for any policy issued or renewed after a date given in the order.
Vermont	Vt. Stat. Ann. tit. 8 § 4688	(a) . . . [I]n a competitive market every insurer shall file with the commissioner all rates and supplementary rate information . . . which are to be used in this state, provided that such rates . . .

STATE	STATUTE	TEXT
Vermont	Vt. Stat. Ann. tit. 8 § 4689	(a) Timing of approval or disapproval. (1) A rate may be disapproved at any time subsequent to the effective date. (2) A rate subject to prefiling may also be disapproved before the effective date.
Virginia	Va. Code Ann. § 38.2-1906 A.	Each authorized insurer subject to the provisions of this chapter shall file with the Commission all rates and supplementary rate information . . . made by it for use in this Commonwealth on or before the date they become effective.
Virginia	Va. Code Ann. § 38.2-1910 A.	If the Commission finds . . . that a rate is not in compliance . . . or is in violation of . . . the Commission shall order that use of the rate be discontinued for any policy issued or renewed after a date specified in the order.

STATE	STATUTE	TEXT
Washington	Wash. Rev. Code Ann. § 48.19.040 (1)	Every insurer or rating organization shall, before using, file with the commissioner every classifications manual, manual of rules and rates, rating plan, rating schedule, minimum rate, class rate, and rating rule . . . which it proposes.
Washington	Wash. Rev. Code Ann. § 48.19.100	If . . . the commissioner finds that a filing does not meet the requirements of this chapter, he shall disapprove such filing, and shall give notice of such disapproval . . .

STATE	STATUTE	TEXT
West Virginia	W. Va. Code § 33-20-4 (a)(1)	Every insurer shall file with the commissioner every manual of classifications, territorial rate areas established . . . rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use for casualty insurance to which this article applies.
West Virginia	W. Va. Code § 33-20-5(a)	If . . . the commissioner finds that a filing does not meet the requirements of this article, he shall send . . . written notice of disapproval of such filing . . .
Wisconsin	Wis. Stat. Ann. § 625.13 (1)	[E]very authorized insurer . . . shall file with the commissioner all rates and supplementary rate information and all changes and amendments thereof made by it for use in this state within 30 days after they become effective.

STATE	STATUTE	TEXT
Wisconsin	Wis. Stat. Ann. § 625.22 (1)	. . . If the commissioner finds after a hearing that a rate is not in compliance with § 625.11, the commissioner shall order that its use be discontinued for any policy issued or renewed after a date specified in the order.
Wyoming	Wyo. Stat. Ann. § 26-14-107	(a) In competitive markets, every insurer shall maintain all rates and supplementary rate information to be used in this state . . . and such information shall be made available to the commissioner upon his request. (b) In noncompetitive markets, every insurer shall file with the commissioner all rates, supplementary rate information and supporting information for noncompetitive markets at least thirty (30) days before the proposed effective date.

STATE	STATUTE	TEXT
Wyoming	Wyo. Stat. Ann. § 26-14-108 (a)	The commissioner shall disapprove a rate for use in a noncompetitive market if he finds pursuant to subsection (b) of this section that the rate is excessive, inadequate or unfairly discriminatory.

APPENDIX C — SURVEY OF STATE STATUTES WHICH HAVE EXPRESSLY ENACTED INSURANCE REGULATORY LAWS IN RESPONSE TO THE McCARRAN-FERGUSON ACT

STATE	STATUTE	TEXT
Alabama	Ala. Code § 27-12-1(a)	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Insurance Regulation Act by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Alaska	Alaska Stat. § 21.36.010	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (P.L. 79-15; ch. 20, 59 Stat. 33), by defining or providing for determination of all the practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting them.

STATE	STATUTE	TEXT
Arizona	Ariz. Rev. Stat. Ann. § 20-441.A.	Among the purposes of this article is the regulation of trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March 9, 1945, 59 Stat. 33, by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Arkansas	Ark. Code Ann. § 23-66-202(a)	The purpose of this subchapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in Public Law 79-15 by defining, or providing for the determination of, all practices in this state which constitute unfair methods of competition or unfair or deceptive

STATE	STATUTE	TEXT
		acts or practices and by prohibiting the trade practices so defined or determined.
California	Cal. Ins. Code § 790	The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, Seventy-ninth Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Colorado	Colo. Rev. Stat. Ann. § 10-3-1101	The purpose of this part 11 is to regulate trade practices in the business of insurance by defining, or providing for

STATE	STATUTE	TEXT
		the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined. No rules or regulations shall be promulgated to adversely affect free and open competition in the sale of insurance.
Connecticut	*Mead v. Burns*, 199 Conn. 651, 509 A.2d 11 (1986)	. . . Congress enacted the McCarran-Ferguson Act, 15 U.S.C. § 1012 (b), which authorized federal regulation of insurance only "to the extent that such business is not regulated by State Law." In response, the National Association of Insurance Commissioners in 1947

STATE	STATUTE	TEXT
		promulgated a model insurance trade practices act to assure continued state supervision of the insurance industry. That model act was the basis for this state's enactment of CUIPA in 1955, and the legislative history at that time demonstrates that the legislature intended to preserve state regulation of insurance practices.
Delaware	Del. Code Ann. tit. 18 § 2301(a)	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, 15 U.S.C. § 1011 et seq., by defining or providing for the determination of all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
Florida	Fla. Stat. Ann. § 626.951(1)	The purpose of this part is to regulate trade practices relating to the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Pub. L. No. 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Georgia	Ga. Code Ann. § 33-6-1	The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining or providing for the determination of all practices in this state which constitute

STATE	STATUTE	TEXT
		unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Hawaii	Haw. Rev. Stat. Ann. § 431:13-101	The purpose of this article is to regulate trade practice in the business of insurance in accordance with the intent of the Congress of the United States as expressed in the act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all acts, methods, and practices which constitute unfair methods of competition or unfair or deceptive acts or practices in the State, and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
Idaho	Idaho Code § 41-1301	The purpose of sections 41-1301 through 41-1322 is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of congress of March 9, 1945 (Public Law 15, 79th Congress [ch. 20, 59 U.S. Stat. at Large 33]), by defining, or proving for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Illinois	215 Ill. Comp. Stat. Ann. 5/421	Declaration of purpose. The purpose of this Article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th

STATE	STATUTE	TEXT
		Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Indiana	Ind. Code Ann. § 27-4-1-1	Sec. 1. The purpose of this chapter is to regulate the trade practices in the business of insurance, in accordance with the intent of Congress as expressed in 15 U.S.C. 1011 et seq., by defining, or providing for the determination of, all such practices which constitute in this state unfair methods of competition and unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
Iowa	Iowa Code Ann. § 507B.1	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, Public Law 15, 79th Congress, by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Kansas	Kan. Stat. Ann. § 40-2401	The purpose of this act is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such

STATE	STATUTE	TEXT
		practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Louisiana	La. Rev. Stat. Ann. § 22:1211	The purpose of this Part is to regulate the trade practices in the business of insurance, in accordance with the intent of congress as expressed in Public Law 15- 79th Congress, by defining or providing for the determination of all acts, methods, and practices which constitute unfair methods of competition and unfair or deceptive acts and practices in this state, and to prohibit the same.
Maine	Me. Rev. Stat. Ann. tit. 24-A § 2151	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent

STATE	STATUTE	TEXT
		of Congress as expressed in the Act of Congress of March 9, 1945, Public Law 15, 79th Congress, by defining or providing for the determination of all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices, by defining or providing for the determination of all such practices in other states by residents of this State which constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined.
Maryland	Md. Code Ann., Ins. § 27-101	The purpose of this title is to regulate trade practices in the business of insurance in accordance with the intent of Congress expressed in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011

STATE	STATUTE	TEXT
		through 1015, by defining, or providing for the determination of, all trade practices in the business of insurance in the State that are unfair methods of competition or unfair or deceptive acts or practices and by prohibiting those trade practices.
Michigan	Mich. Comp. Laws Ann. § 500.2002	The purpose of this uniform trade practices act is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of congress of March 9, 1945 (Public Law 15, 79th Congress as amended), by defining, or by providing for the determination of (under standards or procedures herein prescribed), all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
Minnesota	Minn. Stat. Ann. § 72A.17	The purpose of sections 72A.17 to 72A.32 is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Act of Congress of March 9, 1945 (Public Law Number 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Mississippi	Miss. Code Ann. § 83-5-29	The purpose of Sections 83-5-29 to 83-5-51 is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by

STATE	STATUTE	TEXT
		defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or deceptive practices, and by prohibiting the trade practices so defined or determined.
Missouri	Mo. Ann. Stat. § 375.930.2.	The purpose of sections 375.930 to 375.948 is to regulate trade practices in the business of insurance in accordance with the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing in sections 375.930 to 375.948 shall be construed to create or

STATE	STATUTE	TEXT
		imply a private cause of action for a violation of sections 375.930 to 375.948.
Montana	Mont. Code Ann. § 33-18-101	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in Public Law 79-15 (the McCarran-Ferguson Act, 15 U.S.C. 1011 through 1015), which was approved March 9, 1945, by defining or providing for determination of all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Nebraska	Neb. Rev. Stat. § 44-1522	The purpose of the Unfair Insurance Trade Practices Act is to regulate un-

STATE	STATUTE	TEXT
		fair trade practices in the business of insurance, in accordance with the intent of the Congress of the United States as expressed in Public Law 79-15, by defining, or providing for the determination of, all acts and practices in this state which constitute unfair trade practices and by prohibiting the acts and practices so defined or determined.
Nevada	Nev. Rev. Stat. § 686A.010	The purpose of NRS 686A.010 to 686A.310, inclusive, is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress approved March 9, 1945, being c. 20, 59 Stat. 33, also designated as 15 U.S.C. §§ 1011 to 1015, inclusive, by defining, or providing for the determination of, all such practices in this state

STATE	STATUTE	TEXT
		which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
New Hampshire	N.H. Rev. Stat. Ann. § 417:1	The purpose of this chapter is to regulate trade practices in the business of insurance, in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining or providing for the determination of all such practices which constitute in this state unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
New Jersey	N.J. Stat. Ann. § 17:29B-1	The purpose of this act is to regulate trade practices in the business of insur-

STATE	STATUTE	TEXT
		ance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
New Mexico	N.M. Stat. Ann. § 59A-16-2	A purpose of this article is to regulate trade practices in the insurance business and related businesses in accordance in part with the intent of Congress as expressed in the Act of Congress approved March 9, 1945, being c. 20, 59 Stat. 33, also designated as 15 U.S.C. Secs. 1011 to 1015, inclusive, by defining, or providing for determination of, practices

STATE	STATUTE	TEXT
		in this state which constitute unfair methods of competition or unfair or deceptive acts or practices so defined or determined.
New York	N.Y. Ins. Law § 2401	The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in Public Law 15, 79th Congress, by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
North Carolina	N.C. Gen. Stat. § 58-63-1	The purpose of this Article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts [or] practices and by prohibiting the trade practices so defined or determined.
Oklahoma	Okla. Stat. Ann. tit. 36 § 1201	The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such

STATE	STATUTE	TEXT
		practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Oregon	Or. Rev. Stat. § 731.012	The Insurance Code shall regulate the business of insurance and every person engaged therein in accordance with the intent of Congress as expressed in the Act of March 9, 1945, as amended (Public Law 15, 79th Congress, 15 U.S.C. 1011 to 1014) which states in part that no Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any state for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance.

STATE	STATUTE	TEXT
Pennsylvania	Pa. Stat. Ann. tit. 40 § 1171.2	The purpose of this act is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining or providing for the determination of all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Rhode Island	R.I. Gen. Laws § 27-29-1	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in 15 U.S.C. § 1101 et seq., by defining, or providing for the determination of, all such practices in this state which constitute

STATE	STATUTE	TEXT
		unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this chapter.
South Carolina	S.C. Code Ann. § 38-57-10	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March 9, 1945, (Public Law 15, 79th Congress), by defining, or providing for the determination of, all the practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
South Dakota	S.D. Codified Laws § 58-33-1	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress, ch. 20, 50 U.S. Stat. at Large 33), by defining, or providing for determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Tennessee	Tenn. Code Ann. § 56-8-101	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or pro-

STATE	STATUTE	TEXT
		viding for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.
Vermont	Vt. Stat. Ann. tit. 8 § 4721	The purpose of sections 4721-4733 of this title is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
Virginia	Va. Code Ann. § 38.2-500	The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 through 1015, by defining and prohibiting all practices in this Commonwealth that constitute unfair methods of competition or unfair or deceptive acts or practices.
West Virginia	W. Va. Code § 33-11-1	The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March ninth, one thousand nine hundred forty-five (Public Law fifteen, seventy-ninth Congress), by defining, or providing for the determination of, all such practices in this State

STATE	STATUTE	TEXT
		which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

STATE	STATUTE	TEXT
Alaska	Alaska Stat. § 21.36.030(a)	A person may not make, issue, circulate, . . . or have made, issued, circulated, . . . [a] statement that (1) misrepresents the . . . conditions . . . or terms of an insurance policy; . . . (6) uses a name or title of an insurance policy or class of insurance policies misrepresenting its true nature; . . . (11) is in any other way misleading, false, or deceptive.
	Alaska Stat. § 21.36.040	A person may not make, publish, disseminate, circulate, or place before the

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		public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement with respect to the business of insurance or with respect to a person in the conduct of the person's insurance business, that is untrue, deceptive, or misleading.
Arizona	Ariz. Rev. Stat. Ann. § 20-443	No person shall make, issue or circulate, or cause to be made, issued or circulated any . . . statement: 1. Misrepresenting the terms of any policy. . . .

STATE	STATUTE	TEXT
		4. Using any name or title of any policy or class of policies misrepresenting the true nature of such policy.
	Ariz. Rev. Stat. Ann. § 20-444 A	No person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public . . . or in any other way, any . . . statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

STATE	STATUTE	TEXT
Arkansas	Ark. Code Ann. § 23-66-206	The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: (1) . . . making, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement . . . which: (A) Misrepresents the . . . conditions or terms of any insurance policy; or . . .

STATE	STATUTE	TEXT
		(E) Uses any name or title of any insurance policy or class of insurance policies, misrepresenting the true nature thereof; . . .
California	Cal. Ins. Code § 790.03	The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance: (a) Making, issuing, circulating, or causing to be made, issued or circulated, any . . . statement misrepresenting the terms of any policy . . .

STATE	STATUTE	TEXT
		(b) Making or disseminating or causing to be made or disseminated before the public in this state, . . . or in any other manner . . . any statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading, ...
Colorado	Colo. Rev. Stat. Ann. § 10-3-1104	(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

STATE	STATUTE	TEXT
		(a) . . . Making, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement . . . which: (I) Misrepresents the . . . conditions, or terms of any insurance policy; . . . (V) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; . . .

STATE	STATUTE	TEXT
		(b) . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any . . . representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading; . . . .

STATE	STATUTE	TEXT
Connecticut	Conn. Gen. Stat. Ann. § 38a-816	The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance: (1) . . . Making, issuing or circulating, or causing to be made, issued or circulated, any . . . statement . . . which: (a) Misrepresents the . . . terms of any insurance policy . . . (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof . . . (2) . . . Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be

STATE	STATUTE	TEXT
		made, published, disseminated, circulated or placed before the public . . . or in any other way . . . or statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
Delaware	Del. Code Ann. tit. 18 § 2304	The following are hereby defined as . . . unfair or deceptive acts or practices in the business of insurance:

STATE	STATUTE	TEXT
		(1) . . . No person shall make, issue, circulate or cause to be made, issued or circulated any . . . statement . . . which: (a) Misrepresents the . . . conditions or terms of any insurance policy; or . . . (e) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; . . . (2) . . . No person shall make, publish, disseminate, circulate or

STATE	STATUTE	TEXT
		place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, . . . or in any other way, . . . statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of the insurance business, which is untrue, deceptive or misleading.
Florida	Fla. Stat. Ann. § 626.9541(1)	. . . The following are defined as . . . unfair or deceptive acts or practices:

STATE	STATUTE	TEXT
		(a) . . . making, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement, . . . which: 1. Misrepresents the . . . conditions, or terms of any insurance policy. . . . 5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof. . . . (b) . . . Knowingly making, publishing, disseminating, circulating, or placing before the public, or

STATE	STATUTE	TEXT
		causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public: . . . 4. In any other way, . . . [a] statement containing any . . . representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.
Georgia	Ga. Code Ann. § 33-6-4(b)	The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

STATE	STATUTE	TEXT
		(1) Making, publishing, disseminating, circulating, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public . . . or in any other way . . . [a] statement containing any . . . representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading;
Hawaii	Haw. Rev. Stat. § 431:13-103(a)	The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

STATE	STATUTE	TEXT
		(1) . . . Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which: (A) Misrepresents the . . . terms of any insurance policy; . . . (E) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; . . .

STATE	STATUTE	TEXT
		(2) . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public . . . or in any other way . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive or misleading.

STATE	STATUTE	TEXT
Idaho	Idaho Code § 41-1303(1)	No person shall make, issue, circulate, or cause to be made, issued or circulated, any . . . statement misrepresenting the terms of any policy . . . or use any name or title of any policy or class of policies misrepresenting the true nature thereof.
	Idaho Code § 41-1304	No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, any . . . statement containing any . . . representation or

STATE	STATUTE	TEXT
		statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
Illinois	215 Ill. Comp. Stat. Ann. 5/149(1)	No company doing business in this State . . . or any other person, shall make, issue or circulate or cause or knowingly permit to be made, issued or circulated any estimate, illustration, circular, or verbal or written statement of any sort misrepresenting the terms of any policy issued or to be issued . . . or shall by the use of any name or title of any policy or class of policies misrepresent the nature thereof.

STATE	STATUTE	TEXT
Indiana	Ind. Code Ann. § 27-4-1-4	The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance: (1) Making, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement: (A) misrepresenting the terms of any policy . . . (D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; . . .

STATE	STATUTE	TEXT
		(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way . . . [a] statement containing any assertion, representation, or statement with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.
Iowa	Iowa Code Ann. § 507B.4	The following are hereby defined as . . . unfair or deceptive acts or practices in the business of insurance:

STATE	STATUTE	TEXT
		1. . . . Making, issuing, circulating, or causing to be made, issued or circulated, any . . . statement . . . which . . . : a. Misrepresents the . . . conditions, or terms of any insurance policy. . . . e. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof. . . .

STATE	STATUTE	TEXT
		2. . . . Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public . . . or in any other way, . . . [a] statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive or misleading.

STATE	STATUTE	TEXT
Kansas	Kan. Stat. Ann. § 40-2404	The following are hereby defined as . . . unfair or deceptive acts or practices in the business of insurance: (1) . . . Making, issuing, circulating or causing to be made, issued or circulated any . . . statement . . . which: (a) Misrepresents the . . . conditions or terms of any insurance policy; . . . (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; . . .

STATE	STATUTE	TEXT
		(2) . . . Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, . . . or in any other way . . . [a] statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, which is untrue, deceptive or misleading.
Kentucky	Ky. Rev. Stat. Ann. § 304.12-020	No person shall make or disseminate orally or in other manner any . . . statement, . . . :

STATE	STATUTE	TEXT
		(1) Misrepresenting the terms of any policy . . .
		(2) Using any name or title of any policy or class of policies misrepresenting the true nature thereof.
Louisiana	La. Rev. Stat. Ann. § 22:1214	The following are declared to be . . . unfair or deceptive acts or practices in the business of insurance:
		(1) . . . Making, issuing, circulating, or causing to be made, issued, or circulated any . . . statement . . . that . . . :

STATE	STATUTE	TEXT
		(a) Misrepresents the . . . conditions, or terms of any policy . . .
		. . .
		(f) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof.
		. . .
		(2) . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way

STATE	STATUTE	TEXT
		. . . [a] statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
Maine	Me. Rev. Stat. Ann. tit. 24-A § 2153	No person shall make, issue, circulate, or cause to be made, issued or circulated, any . . . statement misrepresenting the terms of any policy . . . or use any name or title on any policy or class of policies misrepresenting the true nature thereof.

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	Me. Rev. Stat. Ann.tit. 24-A § 2154	No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
Maryland	Md. Code Ann., Ins. § 27-202(1)	A person may not: (1) make, issue, circulate, or cause to be made, issued or circulated

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		an estimate, circular, or statement that misrepresents the terms of a policy issued or to be issued, ...
	Md. Code Ann., Ins. § 27-202(4)	A person may not:
		(4) use a name or title of a policy or class of policies that misrepresents the true nature of the policy or class of policies.
Massachusetts	Mass. Gen. Laws Ann. ch. 176D § 3	The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: —

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		(1) . . . making, issuing, circulating, or causing to be made, issued or circulated, any . . . statement which: —
		(a) Misrepresents the . . . terms of any insurance policy;
		. . .
		(e) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;
		. . .

STATE	STATUTE	TEXT
		(2) . . . making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public . . . or in any other way . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
Michigan	Mich. Comp. Laws Ann. § 500.2005	An unfair method of competition and an unfair or deceptive act or practice in the business of insurance means the

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		making, issuing, circulating, or causing to be made, issued, or circulated . . . [a] statement . . . [that] does any of the following: (a) Misrepresents the terms . . . of an insurance policy. . . . (e) Uses a name or title of an insurance policy or class of insurance policies misrepresenting the true nature of that insurance policy or class of insurance policies. . . .
	Mich. Comp. Laws Ann. § 500.2007	The following are defined as unfair methods of competition and unfair and

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		deceptive acts or practices in the business of insurance:
		Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

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Minnesota	Minn. Stat. Ann. § 72A.20 Subd.1.	. . . Making, issuing, circulating, or causing to be made, issued or circulated, any . . . statement misrepresenting the terms of any policy . . . or using any name or title of any policy or class of policies misrepresenting the true nature thereof, . . .
	Subd. 2.	. . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, . . . or in any other way, . . . [a] statement, containing any assertion, representation, or statement with respect to the business of insurance, or

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		with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading, . . .
Mississippi	Miss. Code Ann. § 83-5-35	The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. (a) . . . Making, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement misrepresenting the terms of any policy . . . or using any name or title of any policy or class of policies misrepresenting the true nature thereof; . . .

STATE	STATUTE	TEXT
		(b) . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public . . . or in any other way . . . [a] statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.
Missouri	Mo. Ann. Stat. § 375.936	Any of the following practices, . . . are hereby defined as unfair trade practices in the business of insurance:

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		(4) . . . making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way . . . [a] statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of his insurance business, which is untrue, deceptive or misleading; . . .

STATE	STATUTE	TEXT
		(6) . . . making, issuing, circulating, or causing to be made, issued or circulated, any . . . statement, . . . which: (a) Misrepresents the benefits, . . . conditions, or terms of any policy; . . . (e) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof; . . .
	Mo. Ann. Stat. § 376.590	1. No . . . insurance company doing business in this state, . . .

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		shall issue or circulate, or cause or permit to be issued or circulated any . . . statement . . . misrepresenting the terms of any policy issued . . . or shall use any name or title of any policy or class of policies misrepresenting the true nature thereof.
Montana	Mont. Code Ann. § 33-18-202	No person shall make, issue, circulate, or cause to be made, issued, or circulated any . . . statement which: (1) misrepresents the . . . conditions, or terms of any insurance policy; . . .

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		(5) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof. . . .
	Mont. Code Ann. § 33-18-203	No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any . . . representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.

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Nebraska	Neb. Rev. Stat. § 44-1525	Any of the following acts or practices, . . . shall be unfair trade practices in the business of insurance: (1) Making, issuing, circulating, or causing to be made, issued, or circulated any . . . statement . . . which: (a) Misrepresents the . . . conditions, or terms of any policy; . . . (e) Uses any name or title of any policy or class of policies which misrepresents the true nature thereof; . . .

STATE	STATUTE	TEXT
		(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any insurer in the conduct of his or her insurance business which is untrue, deceptive, or misleading . . .
Nevada	Nev. Rev. Stat. § 686A.030	A person shall not make, issue, circulate, or cause to be made, issued, or circulated any . . . statement, . . . which:

STATE	STATUTE	TEXT
		1. Misrepresents the . . . conditions or terms of any insurance policy; . . . 5. Uses any name or title of any policy or class of insurance policies misrepresenting the true nature thereof; . . .
	Nev. Rev. Stat. § 686A.040	No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, any . . . statement containing any . . . representation or

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		statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.
New Hampshire	N.H. Rev. Stat. Ann. § 417:4	The following are hereby defined as . . . unfair and deceptive acts and practices in the business of insurance: I.(a) Making, issuing, circulating, or causing to be made, issued or circulated any . . . statement misrepresenting the terms of any policy . . . . . .

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		(e) Using any name or title of any policy or class of policies misrepresenting the true nature thereof; . . . III.(a) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any . . . representation, or statement with respect to any insurer, . . . in the conduct of such person's insurance business, which is untrue, incomplete, deceptive or misleading.

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New Jersey	N.J. Stat. Ann. § 17:29B-4	The following are hereby defined as . . . unfair and deceptive acts or practices in the business of insurance: (1) . . . Making, issuing, circulating, or causing to be made, issued or circulated, any . . . statement misrepresenting the terms of any policy . . . or using any name or title of any policy or class of policies misrepresenting the true nature thereof, . . . (2) . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the

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		public, . . . or in any other way, . . . [a] statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
New Mexico	N.M. Stat. Ann. § 59A-16-4	No person shall make, publish, issue or circulate any . . . statement . . . which: A. misrepresents the . . . conditions or terms of any policy; . . . E. uses any name or title of any policy or class of policies misrepresenting the true nature thereof; . . .

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	N.M. Stat. Ann. § 59A-16-5	No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, any . . . statement containing any . . . representation or statement with respect to any business subject to the superintendent's supervision under the Insurance Code . . . or with respect to any person in the conduct of such business, which is untrue, deceptive or misleading.
North Carolina	N.C. Gen. Stat. § 58-63-15	The following are hereby defined as . . . unfair and deceptive acts or practices in the business of insurance: (1) . . . Making, issuing, circulating, or causing to be made, issued or

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		circulated, any . . . statement misrepresenting the terms of any policy . . . or using any name or title of any policy or class of policies misrepresenting the true nature thereof, . . .
		(2) . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

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North Dakota	N.D. Cent. Code § 26.1-04-03	The following are . . . unfair and deceptive acts or practices in the business of insurance:
		1. . . . Making, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement . . . misrepresenting the terms of any policy . . .
		2. . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any assertion, representation, or

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		statement with respect to the business of insurance or with respect to any person in the conduct of that person's insurance business, which is untrue, deceptive, or misleading.
	N.D. Cent. Code § 26.1-04-07	An insurance . . . company, . . . may not issue, circulate, or use, or cause or permit to be issued, circulated, or used, any . . . statement . . . misrepresenting the terms of any policy . . . or use any name or title of any policy or class of policies misrepresenting the true nature thereof.
Ohio	Ohio Rev. Code Ann. § 3901.21	The following are hereby defined as unfair and deceptive acts or practices in the business of insurance:

STATE	STATUTE	TEXT
		(A) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, . . . any . . . statement misrepresenting the terms of any policy . . . or using any name or title of any policy or class of policies misrepresenting the true nature thereof, . . .
		(B) Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . statement containing any . . . representation, or statement, with respect to the business of

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		insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.
Oklahoma	Okla. Stat. Ann. tit. 36 §1204	The following are hereby defined as . . . unfair and deceptive acts or practices in the business of insurance: 1. . . . Making, issuing, circulating, or causing to be made, issued or circulated, any . . . statement . . . misrepresenting the terms of any policy. . . 2. . . . Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be

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		made, published, disseminated, circulated, or placed before the public, . . . or in any other way . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.
Oregon	Or. Rev. Stat. § 746.075	(1) Make, issue, circulate or cause to be made, issued or circulated, any . . . statement misrepresenting the terms of any policy issued or to be issued . . . . . . (4) Use any name or title of any policy or class of policies misrepresenting the true nature thereof;

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	Or. Rev. Stat. § 746.110	No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public . . . or in any other way . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of the insurance business, which is untrue, deceptive or misleading.
Pennsylvania	Penn. Stat. Ann. tit. 40 § 1171.5	(a) . . . "unfair or deceptive acts or practices" in the business of insurance means: (1) Making, publishing, issuing or circulating any . . . statement . . . which:

STATE	STATUTE	TEXT
		(i) Misrepresents the . . . conditions or terms of any insurance policy; . . . (v) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (2) Making, issuing, publishing or circulating in any manner . . . [a] statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.

STATE	STATUTE	TEXT
Rhode Island	R.I. Gen. Laws § 27-29-4	The following are hereby defined as . . . unfair and deceptive acts or practices in the business of insurance: (1) . . . Making, issuing, circulating, or causing or permitting to be made, issued, or circulated any . . . statement . . . misrepresenting the terms of any policy . . . or using any name or title of any policy or class of policies misrepresenting the true nature thereof, . . . (2) . . . Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the

STATE	STATUTE	TEXT
		public, . . . or in any other way, . . . [a] statement containing any . . . representation, or statement, with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business which is untrue, deceptive, or misleading; . . .
South Carolina	S.C. Code Ann. § 38-57-40	No person may make, issue, circulate, or cause to be made, issued, or circulated any . . . statement misrepresenting the terms of a policy issued or to be issued . . . or use any name or title of a policy or class of policies misrepresenting the true nature thereof.
	S.C. Code Ann. § 38-57-50	No person may make, publish, disseminate, circulate, or place before the pub-

STATE	STATUTE	TEXT
		lic or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public . . . or in any other way . . . [a] statement containing . . . [a] representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive, or misleading.
South Dakota	S.D. Codified Laws § 58-33-5	No person shall make, issue, circulate, or cause to be made, issued, or circulated, any . . . statement misrepresenting the terms of any policy issued or to be issued . . . or use any name or title of any policy or class of policies misrepresenting the true nature thereof.

STATE	STATUTE	TEXT
	S.D. Codified Laws § 58-33-6	No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public . . . or in any other way . . . [a] statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
Tennessee	Tenn. Code Ann. § 56-8-104	The following are hereby specifically defined as . . . unfair or deceptive acts or practices in the business of insurance: (1) . . . Making, publishing, disseminating, circulating, or plac-

STATE	STATUTE	TEXT
		ing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . .or in any other way, . . . [a] statement containing any . . . representation, or statement, with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading or which: (A) Misrepresents the . . . conditions, or terms of any insurance policy; . . . (E) Uses any name or title of any insurance policy or

STATE	STATUTE	TEXT
		class of insurance policies misrepresenting the true nature of such policy or class of policies. . . .
Texas	Tex. Ins. Code Ann. § 21.21	Sec. 1.(a) The purpose of this Act is to regulate trade practices in the business of insurance by defining, . . . all such practices in this state which constitute . . . unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. . . . Sec. 4(1) . . . Making, issuing, circulating, or causing to be made, issued or circulated any . . . statement misrepresenting the terms of any policy . . . or using any name or title of any policy or class of policies misrepresenting the true nature thereof, . . .

STATE	STATUTE	TEXT
		Sec. 4(2) . . . Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . .or in any other way, . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading; . . .
Utah	Utah Code Ann. § 31A-23-302 (1)(a)(i)	A person who is or should be licensed under this title, an employee or agent of that licensee or person who should be licensed . . . may not make or cause to be made any communication that contains false or misleading information, relating to an insurance contract,

STATE	STATUTE	TEXT
		any insurer, or other licensee under this title, including information that is false or misleading because it is incomplete.
Vermont	Vt. Stat. Ann. tit. 8 § 4724	The following are hereby defined as . . . unfair or deceptive acts or practices in the business of insurance: (1) . . . Making, issuing, circulating, or causing to be made, issued or circulated, any . . .statement . . . which: (A) misrepresents . . . the . . . conditions . . . or terms of any insurance policy; or . . . (E) uses any name or title of any insurance policy or

STATE	STATUTE	TEXT
		class of insurance policies misrepresenting the true nature thereof; or . . .
		(2) . . . Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, . . . or in any other way, . . . [a] statement containing any . . . representation, or statement, with respect to the business of insurance or with respect to any person in the conduct of his business, which is untrue, deceptive, or misleading.

STATE	STATUTE	TEXT
Virginia	Va. Code Ann. § 38.2-502	No person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any . . . statement . . . that: 1. Misrepresents the benefits, advantages, conditions or terms of any insurance policy; . . . 5. Uses any name or title of any insurance policy or class of insurance policies that misrepresents the true nature of the policy or policies;
	Va. Code Ann. § 38.2-503	No person shall knowingly make, publish, disseminate, circulate, or place before the public, or cause or knowingly allow, directly or indirectly, to be made, published, disseminated, circulated, or

STATE	STATUTE	TEXT
		placed before the public . . . or in any other way . . . [a] statement containing any assertion, representation or statement relating to (i) the business of insurance or (ii) any person in the conduct of his insurance business, which is untrue, deceptive or misleading.
Washington	Wash. Rev. Code Ann. § 48.30.090	No person shall make, issue or circulate, or cause to be made, issued or circulated any misrepresentation of the terms of any policy . . . or use any name or title of any policy or class of policies misrepresenting the nature thereof.
	Wash. Rev. Code Ann. § 48.30.040	No person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or adver-

STATE	STATUTE	TEXT
		tising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.
West Virginia	W. Va. Code § 33-11-4	The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance: (1) . . . No person shall make, issue, circulate, or cause to be made, issued or circulated, any . . . statement . . .which: (a) Misrepresents the . . . terms of any insurance policy; or . . .

STATE	STATUTE	TEXT
		(e) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; or . . . (2) . . . .No person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public . . . or in any other way, . . . [a] statement containing any . . . representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

STATE	STATUTE	TEXT
Wisconsin	Wis. Stat. Ann. § 628.34 (1)(a)	. . . [N]o person . . . may make or cause to be made any communication relating to an insurance contract, the insurance business, any insurer or any intermediary which contains false or misleading information . . .
Wyoming	Wyo. Stat. Ann. § 26-13-103(a)	No person shall: (i) Make, issue, circulate, or cause to be made, issued or circulated, any . . . statement misrepresenting the terms of any policy issued or to be issued . . . . . . (iv) Use any name or title of any policy or class of policies misrepresenting the true nature thereof.

STATE	STATUTE	TEXT
	Wyo. Stat. Ann. § 26-13-104	No person shall make in any manner in any advertising or other communication medium any advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

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No. 97-303

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

Humana Inc. and
Humana Health Insurance of Nevada, Inc.,

Petitioners,

v.

Mary Forsyth, Marietta Cade,
Willie Andrews, Mary Lou Buehler,
Helen Staves, Randolph Bratton,
and Searle Auto Glass, Inc.,

Respondents.

On Writ of *Certiorari* to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICUS CURIAE* TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C., IN SUPPORT OF RESPONDENTS

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September 18, 1998

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INTEREST OF *AMICUS CURIAE*[1]

Trial Lawyers for Public Justice ("TLPJ") is a national public interest law firm that is dedicated to pursuing justice for the victims of corporate and governmental abuses. Litigating throughout the federal and state courts, TLPJ prosecutes cases designed to advance consumers' and victims' rights, environmental protection and safety, civil rights and civil liberties, occupational health and employees' rights, the preservation and improvement of the civil justice system, and the protection of the poor and the powerless. Through its involvement in precedent-setting and socially-significant litigation, TLPJ seeks to ensure that the civil justice system fully serves its dual purposes – compensating those injured by wrongful conduct and deterring similar conduct in the future. TLPJ is gravely concerned that, if insurance companies are shielded from liability under RICO, these two purposes will be severely undermined.

In this case, the Court must decide whether a health insurer alleged to have committed a pattern of massive fraud against its policyholders should be held liable only for the contractual damages provided for by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132, or should be held liable for treble damages if Respondents prove their RICO claims to a jury. The Court's decision will have broad implications for every American, as virtually no American's life is untouched by the insurance industry. The outcome of this case will determine whether citizens will be foreclosed from using the most effective remedy against organized fraud and abuse against the insurance industry.

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[1]Letters of consent to the filing of this brief have been filed with the Clerk. No counsel for any party authored the brief in whole or in part, and no person or entity other than *amicus curiae* made any monetary contribution to its preparation or submission.

STATEMENT

The sole issue in this case is whether insurance companies are exempt from private civil suits under the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1964(c) (Supp. I 1995), by virtue of the McCarran-Ferguson Act's limitation on Federal regulation of the insurance industry. 15 U.S.C. § 1012(b). The United States Court of Appeals for the Ninth Circuit held that such suits are not barred because they do not conflict with State regulation of the insurance industry, and thus do not "invalidate, impair, or supersede" State insurance laws within the meaning of the McCarran-Ferguson Act. 15 U.S.C. § 1012(b).

Respondents maintain that Petitioner Humana, along with a hospital participating in its preferred provider organization, engaged in an elaborate kickback scheme to defraud its policyholders. Respondents are policyholders under an insurance contract with Humana, under which Humana was contractually obligated to pay 80% of policyholders' hospital stays, and policyholders were obligated for a 20% co-payment. J.A. 117. Respondents allege that Humana secretly obtained discounts from a hospital participating in Humana's preferred-provider organization. *Id.* Instead of passing those discounts on to its policyholders in the form of a reduced co-payment, Humana fraudulently concealed the discounts from Respondents. J.A. 126. The result, Respondents contend, is that in some instances the discount was so large that the total hospital bill was less than the co-payment Respondents were forced to pay on the undiscounted rate. *Forsyth v. Humana, Inc.*, 827 F. Supp. 1498, 1508 (D. Nev. 1993). In other words, Humana more than covered its own costs with the policyholder's co-payment. Respondents further allege that Humana engaged in elaborate deception to conceal the discounts from its insureds and misrepresent the co-pay arrangement through direct mail, television and radio advertisements, and telemarketer solicitations. *Id.* at 1516.

Under ERISA, which does not allow recovery of extra-contractual damages, the district court ordered Humana to

reimburse its policyholders the excess co-payment, *i.e.*, the amount policyholders paid Humana in excess of 20% of the discounted rate. 827 F. Supp. at 1508. The district court also held, however, that Respondents' State law claims, including their State RICO claim, were preempted by ERISA, and that Respondents' Federal RICO claims were barred by the McCarran-Ferguson Act. *Id.* at 1509, 1520. On appeal, the Ninth Circuit affirmed the award of ERISA relief, but reversed the district court's ruling dismissing the Federal RICO claims. *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475, 1480 (9th Cir. 1997). Humana then sought review by this Court, which was granted.

SUMMARY OF ARGUMENT

The result reached by the district court, and urged by Petitioners here, demonstrates why preclusion of civil RICO suits by McCarran-Ferguson enables perpetuation of fraud in the insurance industry. The district court dismissed Respondents' State law claims as preempted by ERISA. However, the ERISA remedy awarded by the district court merely placed Humana in the financial position it would have been in had it not concealed the discounts. RICO, in contrast, was designed to impose more powerful and effective remedies, to undermine the economic power the racketeer derives from its fraud, and to prevent it from repeating its wrongful conduct in the future. The court of appeals' decision reinstating Respondents' RICO claim therefore unleashes a powerful tool for combating insurance fraud.

The lower court's decision, moreover, is entirely consistent with the Congressional purposes underlying RICO. RICO was enacted for the express purpose of eradicating systematic fraud and abuse in every sector of the economy, including the insurance industry. In enacting RICO, Congress recognized that State regulators and law enforcement agencies had insufficient means to combat what had become an increasingly widespread and devastating problem for consumers. Mindful of the States' authority to investigate and prosecute criminally and civilly fraudulent activity within their own borders, Congress specifically

designed RICO to supplement those efforts by providing for criminal and civil prosecution of racketeering activity in interstate and foreign commerce. To ensure the effectiveness of the law, Congress enacted powerful criminal and civil penalties, which include treble damages for businesses or consumers who suffer economic losses as a result of violations of RICO. These penalties create an effective means for private citizens to fight the sort of interstate insurance fraud that State regulators are powerless to address.

Recent Congressional investigations confirm the vital role that RICO can and should play in combating insurance fraud. Such investigations have revealed that gaps in the reach and effectiveness of State insurance regulation has created a climate ripe for interstate and international insurance fraud. Recent years have witnessed several significant instances of interstate and international racketeering activity that have cheated consumers out of their premium payments and their insurance coverage. A handful of reported cases, including this one, bring to light other fraudulent schemes perpetrated by insurance companies, many of which present colorable civil RICO claims. These frauds, occurring in the health, life, property, and casualty insurance industries, cause severe economic impact, costing consumers tens of millions of dollars. As Congress predicted, State regulation alone has been inadequate to redress this wrongdoing.

RICO, on the other hand, is tailor-made for rooting out this type of fraud. In cases of health insurance fraud, such as this case, state law claims against health insurance plans covered by ERISA are preempted. Remedies under ERISA are limited to contractual damages, with no compensatory, consequential, or punitive damages. Even when state law claims are available and not preempted by ERISA, they lack RICO's powerful remedies, and are not as effective in eradicating fraud. Thus, in light of the relative weakness of State and ERISA remedies and the inability of State regulation to reach interstate and international fraud, it is critical that RICO be available to consumers to combat systematic fraud in the insurance industry.

ARGUMENT

II. THE McCARRAN-FERGUSON ACT DOES NOT PRECLUDE CIVIL RICO CLAIMS AGAINST INSURANCE COMPANIES BECAUSE RICO DOES NOT "INVALIDATE, IMPAIR, OR SUPERSEDE" STATE INSURANCE LAWS.

A. RICO's Plain Language Makes Clear That It Does Not Supersede State Law, But Rather Supplements It.

The McCarran-Ferguson Act provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . ." 15 U.S.C. § 1012(b). The starting point for determining whether RICO "invalidates, impairs, or supersedes" State insurance regulations is not the McCarran-Ferguson Act, but RICO itself, which states that:

> Nothing in this title shall supersede any provision of Federal, State, or other law imposing criminal penalties or affording civil remedies in addition to those provided for in this title.

84 Stat. 947 (1970). Because RICO explicitly does not "supersede" State law, an entity sued in a private civil RICO suit may also be prosecuted criminally or civilly by State authorities, such as insurance regulators. RICO therefore does not violate McCarran-Ferguson's proscription on Federal interference in the regulation of the business of insurance.

Further evidence of Congress' intent that RICO supplement, but not supersede, State law is found in its definition of "racketeering activity," which includes "any act . . . which is chargeable under

State law . . ." 18 U.S.C. § 1961(1).[2] Because the statute expressly provides that a racketeer can be prosecuted under both State law and RICO, this Court has interpreted RICO as not in any way "superseding" State law. *See United States v. Turkette*, 452 U.S. 576, 586-87 (1981) ("That Congress included within the definition of racketeering activities a number of state crimes strongly indicates that RICO criminalized conduct that was also criminal under state law, at least when the requisite elements of a RICO offense are present.") *See also Haroco, Inc. v. American Nat'l Bank & Trust Co. of Chicago*, 747 F.2d 384, 392 (7th Cir. 1984), *aff'd*, 473 U.S. 606 (1985) (RICO "supplements," rather than "supplants" state law).

As *Turkette* makes clear, Congress explicitly intended that Federal prosecutions under RICO and States' prosecutions under their own laws take place simultaneously, in order to buttress law enforcement efforts against wrongdoers who were not sufficiently deterred by States' law enforcement alone. Because RICO's civil enforcement provision incorporates the criminal definition of "racketeering," it is logical that *Turkette's* reasoning applies in the civil arena as well.[3] There can therefore be no claim that RICO

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[2] RICO makes it unlawful:

> for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity . . . in which such person has participated as a principal . . . to use or invest, directly or indirectly, any part of such income, or the proceeds of such income, in acquisition of any interest in, or the establishment or operation of, any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce. 18 U.S.C. § 1962(a).

[3] RICO's civil enforcement provision, 18 U.S.C. § 1964(c), also provides for civil enforcement by the Federal government or by private citizens:

> [a]ny person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee.

supersedes State law, even in the civil context; rather, RICO plainly supplements State law. Private civil RICO actions against insurance companies thus do not fall within the McCarran-Ferguson Act's proscription of federal law that "invalidates, impairs, or supersedes" State insurance regulation.

B. Congress Intended That RICO Be Used to Eradicate Organized Fraud in All Sectors of the Economy, Including the Insurance Industry.

RICO's legislative history further reveals that Congress included powerful remedies, including the treble damages provision, because fraud by organized crime had made an "alarming expansion into the field of legitimate business," posing a "major threat to our institutions." 116 Cong. Rec. 607 (Jan. 21, 1970) (remarks of Sen. Byrd). "The vast economic power concentrated in this giant criminal conglomerate constitutes a dire threat to the proper functioning of our economic system." 116 Cong. Rec. 602 (Jan. 21, 1970) (remarks of Sen. Hruska). Congress therefore designed RICO to include the powerful civil enforcement mechanisms "which have been highly effective in removing and preventing harmful behavior in the field of trade and commerce" by undermining the economic power of racketeers. *Id* (remarks of Sen. Hruska). Without these potent civil remedies, modeled on the Federal antitrust laws, "[t]he consumer public will suffer from inflated prices, shoddy goods, and outright frauds." 115 Cong. Rec. 6993 (Mar. 20, 1969) (remarks of Sen. Hruska).

Moreover, Congress fully recognized that, in order for RICO to be effective in eradicating the infiltration of illegal enterprises into legitimate businesses, it must eliminate the economic means for the enterprises to continue their illegal operations in *all* sectors of the economy. SEN. REP. NO. 91-617, at 80-83 (1969). Congress found that fraud by organized syndicates had infiltrated nearly every industry, and that the insurance industry was not "immune from its grasping claws." *Id.* at 76; 115 Cong. Rec. 5874 (Mar. 11, 1969) (remarks of Sen. McClellan). Senator

McClellan, one of RICO's chief sponsors, noted that in addition to its infiltration into the insurance industry in general, fraud by organized syndicates had also infiltrated labor unions, and these syndicates had profited by manipulating insurance contracts. *Id.* Thus, Congress fully intended that RICO's enforcement mechanisms be applicable to patterns of racketeering in the insurance industry.

II. RICO IS A VITAL TOOL IN COMBATING INSURANCE FRAUD.

Recent Congressional investigations into insurance fraud have confirmed what Congress suspected when it enacted RICO in 1970: that States, acting alone, are powerless to combat interstate and international insurance fraud. In the late 1980s and early 1990s, two Congressional subcommittees conducted extensive hearings on insurance fraud. *See* STAFF OF SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMM. ON ENERGY AND COMMERCE, 103D CONG., 2D SESS., *WISHFUL THINKING, A WORLD VIEW OF INSURANCE SOLVENCY REGULATION* 1 (Comm. Print 1994) ("*WISHFUL THINKING*").[4] These subcommittees both found that State insurance regulators lack the resources to prevent and prosecute systematic fraud and corruption in the insurance industry. These investigations underscore the need for more powerful remedies – like RICO – to effectively prevent and deter this type of fraud.

[4] *WISHFUL THINKING* referenced hearings held by Subcommittee in the 1980s and culminating in STAFF OF SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMM. ON ENERGY AND COMMERCE, 101ST CONG., 1ST SESS., *FAILED PROMISES* (COMM. PRINT 1990) and nine hearings held subsequently and culminating in *WISHFUL THINKING*; *see also Hearings Before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs of the United States Senate on U.S. Government Efforts to Combat Fraud and Abuse in the Insurance Industry,* 102d Cong., 1st. Sess. (1991).

A. Gaps in State Insurance Regulation Provide Opportunities for Insurance Scams.

The environment for organized insurance fraud is ripe in part because State regulators are not equipped to control the interstate and international nature of insurance fraud. McCarran-Ferguson's mandate that the States regulate insurance without interference by federal authorities has created gaps in regulation and enforcement of insurance companies, because State regulators can only control activities within their own state's borders. *See WISHFUL THINKING*, at 3. These gaps enable fraudulent insurance companies and their principals to set up shop in one State and then commit interstate fraud on a massive scale. SEN. REP. NO. 102-310, at 6-7 (1992). As a result, State laws and civil enforcement mechanisms are limited in their ability to prosecute organized insurance fraud. RICO helps fill the enforcement gap.[4]

Perpetrators of systematic insurance fraud circumvent or manipulate State regulatory processes, sell insurance illegally, steal consumers' premium payments, and leave their claims unpaid. These frauds occur in all facets of the insurance industry – property, casualty, health and life insurance.[5] *WISHFUL THINKING,* at 51. After the Senate and House subcommittees held

[4] Moreover, many states, including Nevada, where this case arose, permit only administrative proceedings by the insurance commissioner, but not private enforcement actions for violations of the State's unfair insurance practices. Nev. Rev. Stat. § 686A.160. In Nevada, the insurance commissioner also may bring judicial proceedings to prosecute fraudulent acts not specifically defined by the Code. A court may issue cease and desist orders and the commissioner may assess penalties, but no private right of action exists. Nev. Rev. Stat. § 686A.170. Thus, Respondents here had no cause of action under the State insurance code. Because their other State claims were barred by ERISA, they were left with only ERISA's contractual remedy.

[5] The United States is the largest single market for insurance in the world. American consumers purchase about 35 % of the insurance sold in the world, making $482 billion in premium payments annually. *WISHFUL THINKING,* at 51. More than 5,000 insurance companies and operations collectively control almost $2 trillion in assets worldwide. SEN. REP. NO. 102-310, at 1.

their investigations and hearings, they concluded that the current system, which relies on State insurance commissions to regulate, enforce, and penalize insurance companies, lacks sufficiently stringent regulation and sufficiently effective enforcement. *Id.* at 11. *See also* SEN. REP. NO. 102-310. These legislators concluded that their investigation of fraud in the industry had "exposed the top of a number of international white-collar criminal syndicates" and that individuals involved in insurance scams "were equally willing and able to commit other fraudulent activities involving advance fee schemes, stolen or counterfeit securities, tax evasion, and money laundering." SEN. REP. NO. 102-310, at 27, 29. The perpetrators of these scams were able to defraud consumers by capitalizing on weaknesses in the States' regulatory and enforcement schemes.

1. Artful Operators Find Loopholes in State Regulations.

Fraudulent insurance companies and brokers evade detection and prosecution by exploiting loopholes in the States' regulatory schemes. For over a century, State regulation of insurance has been directed at certifying that insurance companies would not be rendered insolvent by claims made by their policyholders. SEN. REP. NO. 102-310, at 6. Each State and the District of Columbia requires an insurance company to obtain a license in order to conduct business in that State. *Id.* In order to obtain a license, the insurance company must prove that it has sufficient assets and surplus capital to pay out claims made against it. *Id.* Yet fraudulent insurance companies and their principals can and do easily evade these requirements, by deceiving State insurance regulators about their assets or by finding loopholes in the law which permit them to sell insurance without a license. *Id.* at 7-8. No matter what form the deception or evasion takes, the net result is the same: consumers pay billions of dollars in premiums each year, and many of them find that their premium payments vanished into the pockets of individuals who ran fraudulent companies that later became insolvent, leaving millions of dollars of unpaid claims. *Id.* at 2.

One of the most notorious exploiters of State regulatory loopholes was Victoria Insurance Company, which, in 1987, with the help of one of its principals – who also was a former Insurance Commissioner for the State of Georgia – obtained a license to sell insurance in Georgia. Victoria obtained this license by briefly holding the requisite $1.2 million in assets, and then transferring them offshore after receiving the license. In reality, then, Victoria was insolvent from the moment it was licensed by the State of Georgia. SEN. REP. NO. 102-310, at 10.

Eighteen months later, Victoria was in receivership. In that eighteen months, Victoria managed to conduct business in all 50 States, selling a variety of insurance products, and collecting $16 million in premiums. SEN. REP. NO. 102-310, at 2. When it went into receivership, Victoria had under $700,000 in assets and over $20 million in unpaid claims. *Id.*

Victoria was able to conduct business in the 49 other States without a license by working with "risk purchasing groups" and "surplus line brokers." Risk purchasing groups are groups of individuals or businesses for which insurance is unavailable in their State. Such risk pooling is authorized by the Liability Risk Retention Act of 1986, 15 U.S.C. §§ 3901 *et seq.* Risk purchasing groups can purchase insurance from an insurer not licensed in the purchasing group's members' State. SEN. REP. NO. 102-310, at 9. As a result, an insurance company selling to a risk retention group could be licensed, for example, only in Florida, but sell insurance to residents of Wisconsin and be free from oversight by Wisconsin insurance regulators.

Similarly, surplus line carriers sell insurance to people or businesses with risks that cannot be insured by the person's or business' resident State-licensed carriers. However, States vary in their requirements for permitting out-of-State insurers to sell surplus lines insurance. Some have "white lists," identifying "acceptable" surplus line brokers, and some have "black lists," identifying "unacceptable" brokers. Other States permit surplus line brokers to sell insurance if they meet certain reporting

requirements, but do not require them to meet any solvency requirements. SEN. REP. NO. 102-310, at 8-9.

Through these and other mechanisms, Victoria evaded scrutiny by State regulators outside of Georgia. Victoria's activities demonstrate how a fraudulent insurance company can dupe one State regulator, or possibly choose a lenient State in which to apply for a license, and then use risk purchasing groups and surplus line brokers to transact business in other States where regulation of insurance companies might be more stringent. This type of activity led one Congressional investigatory committee to conclude that "current State supervision in the U.S. is lacking in the key areas needed to achieve national solvency regulation. The major reasons are limited legal authority, inadequate resources, and poor coordination." *WISHFUL THINKING,* at 11.

2. Regulators Lack the Resources to Fully Assess Insurance Companies' Solvency.

Insurance fraud is also made possible because insurance regulators lack the resources to investigate and determine whether the assets listed on insurance companies' financial statements genuinely exist. SEN. REP. NO. 102-310, at 25. Because of these insufficient enforcement resources, some fraudulent insurance companies have been able to obtain State licenses by listing "assets" on their financial Statements that did not actually exist. This places consumers at risk that their insurance claims will not be paid.

One example of this practice involved an insurance company that listed as an asset an assignment interest in Government National Mortgage Association (GNMA) securities, claiming that the securities were assigned to the company by their owner. "[G]iven the respectability, security and legitimacy surrounding U.S. government securities, the GNMA bonds were extremely marketable and minimally scrutinized by regulators." SEN. REP. NO. 102-310, at 24. As it turned out, however, the insurers "were apparently using the [identifying] numbers of legitimate, actual

GNMA bonds without the knowledge or consent of the true owners." *Id.* at 25. In the most egregious case, two different insurance companies claimed to be leasing the same pool of GNMA securities at the same time. *Id.*

These companies were able to obtain licenses to sell insurance because "[s]ome State insurance departments appear to be overburdened and without the resources to investigate the authenticity of each asset claimed by each insurance company within its jurisdiction." SEN. REP. NO. 102-310, at 25. As a result, State insurance commissioners have called for increased assistance in combating organized insurance fraud. *See id.* at 23 ("[a]ll of the State insurance regulators at the July 19 [1991] hearing called for some type of additional federal assistance above and beyond making insurance fraud a federal offense.") One of these State regulators "saw the federal role in insurance regulation as filling the gaps in current State regulation, not in duplicating what the States already do."' *Id.* Allowing prosecution of private civil RICO actions satisfies those calls for stepped-up enforcement.

3. Offshore Insurance and Reinsurance Companies Are Unregulated in the United States Yet Do Business Here By Evading State Regulators.

Americans also lose millions of dollars each year to fraudulent offshore insurance and reinsurance companies and brokers. Offshore insurance and reinsurance companies, which are not regulated at all in the United States, comprise 40% of the commercial insurance market in the United States. *WISHFUL THINKING,* at 5. In 1992, American consumers paid more than $8.4 billion to foreign reinsurers, and also purchased substantial insurance coverage from offshore insurance companies. *Id.* at 51. While these companies are headquartered in various countries in Asia, the Caribbean, or Europe, they maintain offices in the United States, where they sell their products free from oversight by State regulators. In California alone, regulators predicted that

in 1992 consumers would pay $300 million in premiums to offshore reinsurers, and that Californians would incur $100 million in losses because of fraud by these companies. *Id.* at 23.

Offshore reinsurance companies frequently are "largely unregulated" in their countries and operate under "totally secretive conditions." SEN. REP. NO. 102-310, at 3. American regulators have no control over the solvency requirements for reinsurance and insurance companies domiciled overseas, yet these offshore insurers are permitted to sell reinsurance to licensed insurers in the United States. A foreign-owned subsidiary in the United States is subject to State regulation, but the foreign-domiciled parent, which controls the assets of the company and makes ultimate decisions as to whether claims are paid, are not. *WISHFUL THINKING,* at 51-53. Moreover, most policyholders, who are not parties to reinsurance agreements, are unaware that their insurer has purchased reinsurance. SEN. REP. NO. 102-310, at 5. The reinsurer therefore has no legal obligation to the policyholder, but when a claim must be paid, the solvency of the reinsurer determines whether the claim will be paid by the insurer. *Id.*

Operating along with brokers in this country, fraudulent offshore insurers and reinsurers have engaged in massive racketeering fraud against American consumers. The most prominent example of such an enterprise was a scam perpetrated against World Life and Health Insurance Company of Pennsylvania. Alan Teale, who also operated Victoria Insurance, again set up shop in Georgia acting as a broker for offshore reinsurance sold to World Life and Health. SEN. REP. NO. 102-310, at 14. Teale's network of Georgia brokers and intermediaries were exempt from Georgia insurance regulations because they were not in the business of insurance as defined by the Georgia regulations. This loophole in Georgia is also true for other States. *Id.* at 16-17.

Operating without regulatory oversight in the United States, Teale acted as a broker for reinsurance companies that also were unregulated in the United States. SEN. REP. NO. 102-310, at 16. Teale and his operators sold millions of dollars of phony reinsurance to World Life and Health, ultimately causing its financial collapse when it could not pay out claims, and leaving consumers without the insurance for which they had paid. *Id.* at 15-17.[6]

Teale's empire operated along with four offshore reinsurance companies with offices in the United States. Although their financial statements indicated otherwise, were seriously underfunded. SEN. REP. NO. 102-310, at 20. They listed phony assets, mostly in the form of worthless or overvalued securities, as proof of their financial solvency. *Id.* Some of these paper assets included bogus bonds purportedly issued by an Indian tribe, the identity of which could not be verified by regulators. *Id.* at 19. It was not until the Senate Subcommittee investigated the collapse of World Life and Health that it was discovered that the "tribe" was "a sham, run by a group of 'white' or 'Anglo' Americans for the sole purpose of financial self-enrichment." *Id.*

That Alan Teale surfaced repeatedly as a subject of Congressional investigators demonstrates how massive and widespread fraud can be orchestrated by a single operator. His ability to orchestrate these widespread and devastating fraudulent schemes underscores the weaknesses in the ability of State regulatory systems to combat this type of fraud.

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[6]Many of the individuals involved in this scam were criminally prosecuted under RICO. DEP'T. LAB. OFF. INSP. GEN. SEMIANN. REP., Apr. - Sept. 30, 1996, at 40-41.

4. Fraud in MEWAs (Multiple Employer Welfare Arrangements) Leaves Thousands of Consumers without Needed Health Insurance Coverage and Bilks Small Businesses of Premium Payments.

Small businesses and their employees are particularly vulnerable to insurance fraud committed by illegitimate multiple employer welfare arrangements ("MEWAs"). MEWAs, which often operate legitimately, provide affordable health insurance coverage to the employees of small businesses and non-profit organizations by pooling the employees of several employers into one group. Because traditional insurance has become virtually unaffordable for many small employers, they are extremely vulnerable to fraudulent MEWA operators offering low-cost insurance for their employees. Some of these employers and their employees have participated in MEWAs only to find that millions of dollars of their premiums have gone to support the lavish lifestyle of the MEWA principals who embezzle premium payments and then leave millions of dollars in unpaid claims after the MEWA or its underwriter becomes insolvent. The victims of this fraud and abuse typically are people of modest incomes who acquire the insurance through their employers because they otherwise could not afford their own insurance. *See* SEN. REP. NO. 102-262, at 6-7 (1992).

The opportunities for fraudulent MEWA operators are created in large part by a regulatory gap in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*[7] While ERISA precludes most State regulation of the business ERISA plans, it "saves" State regulation of the business insurance, as that phrase is defined in the McCarran-Ferguson Act. 29 U.S.C. § 1144(b)(2)(A). Thus, to the extent a MEWA is

[7]In addition to the regulatory gap creating an environment ripe for fraud, ERISA's broad preemption provision creates a civil enforcement gap as well. *See* II.B., *infra*.

underwritten by an insurance company, the insurance company is subject to State licensing and solvency requirements. 29 U.S.C. § 1144(b)(6)(A). Such an insurance company, like any other insurance company, must, in order to operate in a State, obtain a license from the State insurance commission. The State regulators review its assets to determine that it is financially able to pay out claims. On the other hand, a "self-funded" MEWA, *i.e.*, one that is underwritten solely by the premium payments by the participating employers or unions, rather than by an insurance company, is exempted from regulation by the States. 29 U.S.C. § 1144(b)(6)(B).[8] Because ERISA contains no licensing or solvency requirements, no regulatory agency on the State or Federal level reviews the financial vitality of non-insurance-company MEWA sponsors to ensure that they own the assets necessary to pay claims. *Hearing Before the Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce of the House of Representatives*, 105th Cong. 2d. Sess. 14 (1997) (testimony of Kathleen Sebelius, Commissioner of Insurance, State of Kansas). Thus, a "self-insured" MEWA can avoid the principal purpose of insurance regulation – ensuring availability of assets to pay consumers' claims – by asserting that no insurance company is involved in underwriting its activities. SEN. REP. NO. 102-262, at 8.

Seizing on this hole in the regulatory scheme, some fraudulent MEWA operators – even if they were not sponsored by an employer or union – sought to avoid State licensing and solvency requirements by arguing that, because they were self-insured, they were covered only by ERISA. "ERISA has thus become a tactical legal weapon, freely used by many fraudulent MEWAs against the threat of State regulation." SEN. REP. NO. 102-262, at 9. By avoiding State solvency requirements, the typical fraudulent MEWA will engage in a "classic Ponzi scheme in which today's

[8]As originally enacted, ERISA was unclear as to whether State insurance commissions would regulate insurance companies underwriting MEWAs. In 1983, Congress amended the statute to clarify the States' jurisdiction over these insurance companies. 29 U.S.C. § 1144(b)(6).

benefit claims are paid out of tomorrow's premium monies." *Id.* at 6.

In one case of MEWA fraud, the operator of the MEWA, shielding himself from State insurance regulation by claiming the MEWA was governed solely by ERISA, falsely assured his customers that he was fully insured by Lloyd's of London and other reputable insurers, even though no such insurance exists. The MEWA operator, from his location in California, obtained approximately $5.8 million in premiums from consumers nationwide, but used the proceeds for his own personal use. Ultimately, the MEWA became insolvent, and the participants were left with over $3.7 million in unpaid medical claims. The operator was later convicted of wire fraud and money laundering. DEP'T. LAB. INSP. GEN. SEMIANN. REP. OCT. 1, 1996 - MAR. 31, 1997, at 45-46.

As a result of these evasive tactics by fraudulent MEWAs, many States began to recognize the need to regulate MEWAs that were not in fact sponsored by employers or unions and were not underwritten by insurance companies. However, as a result of this stepped-up State regulation, a new type of MEWA emerged, demonstrating the ability of fraud perpetrators to adapt themselves to new regulatory climates and evade the scrutiny of regulators. This new type of MEWA is a "bogus union" MEWA, sponsored by a "union" whose sole purpose is to operate the MEWA, and not to provide representation to workers. DEP'T. LAB. INSP. GEN. SEMIANN. REP. OCT. 1, 1996 - MAR. 31, 1997, at 46.

Two "bogus union" officials pled guilty in 1996 to Federal racketeering charges for forming a union solely for the purpose of selling fraudulent insurance. DEP'T. LAB. INSP. GEN. SEMIANN. REP. APR. 1, - SEPT. 30, 1996, at 42. Thomas Cucuro and Joseph Bartolomeo pled guilty to soliciting and receiving $300,000 in kickbacks from insurance brokers who sold insurance to employee benefit plans affiliated with Cucuro's and Bartolomeo's union. The case came to the attention of law enforcement officials after the employee benefit fund was placed under the control of a court-

appointed trustee as a result of the fund's outstanding $6 million of unpaid medical claims. *Id.* The Inspector General of the United States Department of Labor concluded that "[t]his case exposed a weakness in the Government's regulatory scheme by permitting what is, in essence, an insurance operation to assume the cloak of ERISA preemption, those avoiding more stringent regulation by State Insurance Commissioners." *Id.* at 43. In light of the difficulties State insurance regulators face in preventing and prosecuting MEWA fraud, it is apparent that additional enforcement mechanisms are drastically needed. RICO's civil enforcement mechanism provides the most potent remedies and effective deterrent for this type of fraud.

B. No Other Remedies Are As Effective As RICO in Combating White Collar Crime and Pattern Corporate Fraud.

1. This Court's Liberal Construction of RICO Allows Private Plaintiffs to Use its Treble Damages Remedy to Fight Fraud in Significant Cases Involving Patterns of Fraud, Even Outside of Organized Crime.

RICO's broad applicability to patterns of fraud outside the realm of organized crime is due to the statute's liberal construction. Congress specified that RICO should "be liberally construed to effectuate its remedial purposes." 84 Stat. 947 (1970). This Court has repeatedly recognized and applied this provision, and has repeatedly reaffirmed that the statute is to be broadly and liberally construed. *See Holmes v. Securities Investor Protection Corp.*, 503 U.S. 258, 274 (1992); *H.J., Inc. v. Northwestern Bell Telephone* Co., 492 U.S. 229, 249 (1988); *Sedima, S.P.R.L. v. Imrex* Co., 473 U.S. 479, 497-98 (1985); *United States v. Turkette*, 452 U.S. 576, 587, 593 (1981). As this Court has also recognized, "Congress knew what it was doing when it adopted commodious language capable of extending beyond organized crime." *H.J., Inc. v. Northwestern Bell Tel. Co.*, 492 U.S. at 246.

RICO is thus a crucial part of the arsenal available to those combating white collar crime and patterns of fraud.[9] RICO serves to combat such patterns of fraud in two ways: it is "both preventative and remedial." *Turkette*, 452 U.S. at 593. A number of courts have noted that RICO is a powerful and effective addition to the legal weapons that may be brought to bear against fraudulent enterprises. In *Genty v. Resolution Trust Corp.*, 937 F.2d 899, 910 (3d Cir. 1991), the court observed:

> Congress supplemented the criminal penalties of RICO with this extraordinary [treble damage] civil provision in furtherance of its concern in protecting the public from the evils of racketeer-influenced enterprises. The criminal and civil penalties in the Act thus comprise sharply-cutting edges of a double-edged sword to strike more completely the insidious influences plaguing our nation's enterprises. . . . And as we have previously declared, Congress enlarged "the number of tools with which to attack the invasion of the economic life of the country by the cancerous influence of racketeering activity." *United States v. Frumento*, 563 F.2d 1083, 1090 (3d Cir. 1977).

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[9] It seems likely that RICO has not been as effective a deterrent to fraud by insurance companies as it has been to fraud by other entities because of the possibility that courts might find that RICO claims against insurers are barred by the McCarran-Ferguson Act. Two courts of appeals have barred RICO suits against insurance companies. *Doe v. Norwest Bank Minnesota*, 107 F.3d 1297, 1306-08 (8th Cir. 1997) (RICO actions barred by McCarran-Ferguson); *Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384, 392-93 (6th Cir. 1996) (same). Others, however, have permitted juries to hear those claims. These cases demonstrate the type of frauds RICO is necessary to redress. *See also Schroder v. Acceleration Life Ins. Co.*, 972 F.2d 41 (3d Cir. 1992) (reversing grant of summary judgment in favor of insurer on the plaintiffs' RICO claim, which alleged that the insurer promised to pay benefits it never intended to pay and that it knowingly calculated benefits improperly); *Ocean Energy, II v. Alexander & Alexander*, 868 F.2d 740 (5th Cir. 1989) (reversing grant of summary judgment in favor of insurer on the plaintiffs' RICO claims, which alleged that the insurer made false representations about its insurance program in mailings and that its insurance programs violated state law).

The key to RICO's unique effectiveness is its treble damages remedy, which has the powerful effect of encouraging private parties to enforce the act's prohibitions against white collar crime and systemic fraud. As this Court has said with respect to an analogous provision in the Clayton Act, "Congress created the treble-damages remedy . . . precisely for the purpose of encouraging private challenges to . . . violations." *Reiter v. Sonotone Corp.*, 442 U.S. 330, 344 (1979). *See also Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220, 241 (1987) (treble damages provision creates "vigorous incentives for plaintiffs to pursue RICO claims"). The treble damages remedy also serves to deter white collar crime, and to ensure that the victims of white collar crimes will be adequately compensated for all of their losses, where single damage remedies only compensate victims for the more narrow category of losses recognized by traditional legal remedies. *See Blue Shield v. McCready*, 457 U.S. 465, 472 (1982) (treble damages remedies of the antitrust laws create a "private enforcement mechanism that . . . deter[s] violators . . . and provide[s] ample compensation to the victims. . . .").

Courts and commentators have recognized that traditional legal damages often do not fully compensate victims. "[T]reble damages . . . go beyond the scope of compensatory damages and make the victim whole for any accumulative harm. . . . Accumulative harm is that harm falling outside the range of legal damages, too elusive and indeterminate for adequate measurement by traditional damage principles. . . ." Judith Morse, *Treble Damages Under RICO: Characterization and Computation*, 61 Notre Dame L. Rev. 526, 528 and 528 n.13 (1986) (citations omitted). RICO's treble damages help ensure that a plaintiff injured by a violation of RICO will receive what they deserve: a "complete recovery." *Carter v. Berger*, 777 F.2d 1173, 1176 (7th Cir. 1985).

2. No Alternative Adequate Remedies Exist to Combat Fraud by Employee Benefit Plans Because ERISA Preempts a Wide Variety of State Causes of Action.

RICO's powerful and effective remedies are particularly crucial with respect to health insurance plans covered by ERISA, because ERISA's expansive preemption provisions have been interpreted as preempting a wide range of State statutory and common law remedies for the victims of patterns of fraud against health insurance plans.

ERISA's Preemption Clause, 29 U.S.C. § 1144(a), provides that ERISA supersedes any and all State laws that relate to, refer to or have a connection with any employee benefit plan. The only exception to this broad preemption clause is ERISA's Savings Clause, 29 U.S.C. § 1144(b)(2)(A), which preserves from Federal preemption State laws regulating the business of insurance. In determining whether a State cause of action regulates the business of insurance, this Court has held that courts should use three criteria used for the McCarran-Ferguson Act: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-43 (1985). This Court has also added that, to be exempt from ERISA's preemptive scope under ERISA's Savings Clause, a State law must be specifically directed toward the insurance industry. *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41, 48-50 (1987).

Courts employing these criteria have regularly found that nearly every State law cause of action that might be employed against a systemic fraud by an insurance company is not a regulation of the business of insurance, and thus *is* preempted by ERISA. Accordingly, the district court in this case dismissed Respondents' State RICO claims as preempted by ERISA. 827 F. Supp. at 1509. A number of other courts have found that causes of action

arising from State deceptive trade practice acts are preempted by ERISA, generally on the grounds that those causes of action are not aimed exclusively at the insurance industry. *See, e.g., Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993) (claims against insurer under West Virginia Unfair Trade Practice statute are preempted by ERISA); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir.) (ERISA preempts private right of action created by California Insurance Code for unfair insurance practices), *cert. denied*, 492 U.S. 906 (1988); *Ryan v. Fallon Community Health Plan, Inc.*, 921 F. Supp. 34 (D. Mass. 1996) (ERISA preempts claims under Massachusetts statute prohibiting unfair and deceptive insurance practices); *McManus v. Travelers Health Network of Texas*, 742 F. Supp. 377 (W.D. Tex. 1990) (ERISA preempts the Texas Deceptive Trade Practices Act, as it "is not 'specifically directed' toward the insurance industry"); *Worthington v. Metropolitan Life Ins. Co.*, 688 F. Supp. 298 (S.D. Tex. 1987) (ERISA preempts claims under Texas Insurance Code and Texas Deceptive Trade Practices Act). Courts have also frequently held that ERISA preempts causes of action for State common law fraud. *See, e.g., Lister v. Stark*, 890 F.2d 941 (7th Cir. 1989), *cert. denied*, 498 U.S. 1011 (1990); *Amos v. Blue Cross-Blue Shield*, 868 F.2d 430 (11th Cir.), *cert. denied*, 493 U.S. 855 (1989); *Sandler v. Marconi Circuit Technology Corp.*, 814 F. Supp. 263 (E.D.N.Y. 1993); *Barr v. American Cyanamid Co.*, 808 F. Supp. 752 (W.D. Wash. 1992).

Moreover, under ERISA, an award of attorney's fees is discretionary. *See* 29 U.S.C. § 1132(g) ("the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.") Advocates for elderly and employees' rights have noted that the inconsistent and unpredictable results caused by this provision, and the possibility that even a prevailing litigant will be denied a fee award, have resulted in attorneys' unwillingness to risk undertaking litigation. *See* AMERICAN ASS'N OF RETIRED PERSONS, STATEMENT BEFORE THE WORK GROUP ON ENFORCEMENT OF THE ADVISORY COUNCIL ON EMPLOYEE WELFARE AND PENSION BENEFIT PLANS OF THE U.S. DEP'T OF LABOR, Aug. 20, 1990, at 4; *Proposals to Strengthen ERISA*

Enforcement: Hearing Before the Subcomm. on Labor of the Senate Comm. on Labor and Human Resources, 101st Cong., 2d Sess., 8 (1990) (statement of Jeffrey Lewis of the National Employment Lawyers Association). RICO, by contrast, more definitively provides for recovery of attorney's fees. *See* n.3, *supra*.

In this case, if this Court were to reverse the Court of Appeals' decision, Humana would be liable only under ERISA. *See* 114 F.3d at 1475 (affirming district court's judgment for damages under 29 U.S.C. § 1132(a)(1) for the amounts they were forced to pay above their co-payment). The district court dismissed the Respondents' State law claims, including their State RICO claim, as preempted by ERISA. *Forsyth v. Humana, Inc.*, 827 F. Supp. at 1509.[10] ERISA remedies provide only that Humana return the wrongfully obtained portion of the co-payment. Under ERISA, then, Humana would only be required to refund to the policyholder the amount Humana would have owed the policyholder had it not committed fraud. Without the threat of RICO's more powerful remedies, an insurance company engaging in such a scheme risks only having to pay back to the consumer what it was originally owed. RICO's remedies – including treble damages and attorney's fees – create more powerful incentives for enforcement and serve as a more effective deterrent in preventing future cases of such fraud.

CONCLUSION

For these reasons, the decision below should be affirmed.

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[10]The Court of Appeals did not review this ruling and it is not before this Court. *Forsyth v. Humana*, 114 F.3d at 1474.

Respectfully submitted,

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No. 97-303

In The

Supreme Court of the United States

October Term, 1997

HUMANA, INC., AND
HUMANA HEALTH INSURANCE OF NEVADA, INC.,

Petitioners,

v.

MARY FORSYTH, MARIETTA CADE,
WILLIE ANDREWS, MARY LOU BUEHLER,
HELEN STAVES, RANDOLPH BRATTON,
AND SEARLE AUTO GLASS, INC.,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

AMICUS CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS SUGGESTING AFFIRMANCE OF THE DECISION

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INTEREST OF THE NAIC*

The National Association of Insurance Commissioners (NAIC) is a non-profit, unincorporated association established in 1871, whose membership consists of the principal insurance regulatory officials of the 50 States, the District of Columbia, the territories and insular possessions of the United States.

In submitting this *amicus curiae* brief, the NAIC seeks to demonstrate its interest in this proceeding and to fulfill the mission of the NAIC, as set out in its Constitution, to:

> * * * assist state insurance regulators, individually and collectively, in serving the public interest in achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:
>
> 1. Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
> 2. Promote the reliability, solvency, and financial solidity of insurance institutions; and
> 3. Support and improve State regulation of insurance.

All of these interests are served by the preservation of the civil Racketeer Influenced and Corrupt Organizations Act

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Amicus states pursuant to Rule 37.6 that no counsel for a party authored this brief in whole or in part and no person or entity, other than the *amicus curiae*, made a monetary contribution to the preparation or submission of this brief. The parties have consented to the filing of this *amicus curiae* brief. Stipulations indicating their consent have been filed with the Clerk of the Court.

(RICO), 18 U.S.C. § 1964(c) (1994 & Supp. I 1995), as a tool available for fighting fraud by and against insurance companies.

The NAIC and its members, the principal insurance regulatory officials, resolutely believe RICO can and does enhance effective enforcement of state insurance laws and does not in any way disrupt or undermine their regulatory efforts, contrary to Petitioners' assertions.

One of the most important activities conducted by the members of the NAIC is the development and drafting of model statutes and regulations to address common national problems. These models are intended to serve as guideposts for members to assist them in presenting appropriate insurance legislation for enactment in the various state legislatures and in adopting appropriate regulations for more uniform and effective regulation of insurance in the States.

Nevada has enacted specific laws regarding "Trade Practices and Frauds" by insurers. *See* NEV. REV. STAT. Title 57 §§ 686A.010 to 686A.310 (1997). Nevada's laws are substantially derived from the NAIC's model Unfair Trade Practices Act[1], originally developed in 1947.[2] The NAIC, then, is uniquely well-suited to inform this Court concerning the purposes and intent of the statutes in

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[1] *NAIC Model Laws, Regulations and Guidelines,* Vol. IV, p. 880, 1995.

[2] Between 1947 and 1989, the model was titled The Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance. In 1989, the model's title was shortened to eliminate its long and ungainly name. *NAIC Proceedings* 1990 Vol. IA p. 146.

question and, most importantly, their interpretation and interaction with federal statutes.

Petitioners appear to believe that these Nevada insurance laws are invalidated, impaired or superseded by the application of civil RICO in contravention of the McCarran-Ferguson Act. The NAIC believes otherwise. Civil RICO serves to enhance the enforcement of Nevada's laws regarding Trade Practices and Frauds, consistent with the intent of the NAIC model act not to interfere with common law and statutory remedies available to private litigants.

The NAIC remains very active in supporting its members' ongoing battles against insurance fraud and deceptive practices of insurers. The NAIC has had for many years a standing committee on antifraud issues.[3] Committee members meet at least quarterly with representatives of the Federal Bureau of Investigation, Department of Labor, Postal Inspection Service and other

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[3] The current mission of the committee is to serve the public interest by assisting the commissioners, individually and collectively, in the following fundamental antifraud activities: 1) promotion of the public interest through the detection, monitoring and appropriate referral for investigation of insurance crime, both by and against consumers; 2) provision of assistance to the insurance regulatory community through the maintenance and improvement of electronic databases regarding fraudulent insurance activities; 3) disseminate the results of research and analysis of insurance fraud trends as well as case-specific analysis to the insurance regulatory community and state and federal law enforcement agencies; and 4) provision of the liaison function between insurance regulators, law enforcement and other specific antifraud organizations.

federal, state and international law enforcement officials to address antifraud issues relating to the insurance industry.

As recently as 1995, the committee developed an additional model, titled the Insurance Fraud Prevention Model Act[4] (Fraud Act), to further enhance existing state laws. Section 1 of the Fraud Act sets out its purpose as:

> * * * to permit full utilization of the expertise of the commissioner to investigate and discover fraudulent insurance acts more effectively, halt fraudulent insurance acts and assist and receive assistance from state, local and federal law enforcement and regulatory agencies in enforcing law prohibiting fraudulent insurance acts.

The Fraud Act urges States to create professional fraud fighting units within commissioners' offices. These units are designed to investigate and help prosecute various types of civil and criminal acts committed by insurance entities and insureds. To date, approximately 36 States have responded by establishing units, and all of them rely on federal statutes and resources to supplement their fraud fighting efforts.

But even with such aggressive measures undertaken by commissioners, not one State has attempted to totally occupy the "field" of legislation related to insurance fraud activities. In fact, many commissioners have made powerful use of civil RICO as an additional tool in their regulatory arsenal. Ever since the right of a liquidator of an insolvent insurance company to bring a civil RICO

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[4] *NAIC Model Laws, Regulations and Guidelines*, Vol. IV, p. 880, 1990.

action was recognized by a federal court of appeals in *Schacht v. Brown*, 711 F.2d 1343 (7th Cir. 1983), commissioners have successfully been initiating civil RICO actions against the perpetrators of insurance fraud. In fact, according to the authors of *RICO: Law, Practice, and Issues in the Context of Insurer Insolvency*:[5]

> Civil RICO is probably the single most effective deterrent that presently exists against national and international conspiracies to evade oversight by insurance regulators and to defend consumers of insurance products.[6]

The continued partnership of state and federal criminal and civil laws and remedies enacted to fight insurance fraud is of great national importance. McCarran-Ferguson permits the application of such generalized federal laws as civil RICO so long as state laws regulating the business of insurance are not "invalidated, impaired or superseded." Therefore, the NAIC urges the Court to affirm the decision of the Court of Appeals for the Ninth

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[5] Hon. James E. Long, North Carolina Insurance Commissioner and Donald M. Wright, *Journal of Insurance Regulation*, Vol. 9, No. 3, p. 344 (March 1991).

[6] *Id.* at p. 345. "Along with banking and securities, insurance is one of the most cash-intensive industries. Thus, it is a natural attraction for criminal fraud. Indeed, insurance is especially attractive for attempts at illicit fraudulent activity, because the premium is paid up front for a performance that may or may not occur. The nature of insurance transactions – involving agents, brokers, insurance carriers, reinsurers, and insureds – creates an environment where criminal activity that tends to involve many people working on a common plan of criminal activity or conspiracy can arise. This is the very type of crime that RICO was envisioned to combat – 'white collar' crime." *Id.* at p. 346.

Circuit. This is consistent with statutory law and common law and is in the best interests of insurance consumers, whom commissioners are charged by both State and Federal law to protect.

SUMMARY OF ARGUMENT

1. A plain reading of the McCarran-Ferguson Act does not indicate field pre-emption. Only federal statutes that "invalidate, impair, or supersede" state insurance laws are pre-empted. In order to determine whether civil RICO is pre-empted by the Act, courts must evaluate its effect on specific state laws regulating the business of insurance.

2. Nevada's laws regarding Trade Practices and Frauds are derived from the NAIC's model Unfair Trade Practices Act. Neither these laws or the model act were intended to create or extinguish aggrieved policyholders' private rights of action under state or federal law.

3. The job of an insurance commissioner is complex and demanding, however, state legislators have carefully chosen not to preclude private rights of action to pursue claims against insurers committing fraud and misrepresentation.

4. Congress intends the McCarran-Ferguson Act to broadly pre-empt federal statutes. The Act protects state laws that possess the end, intention, or aim of adjusting, managing, or controlling the business of insurance. Federal statutes that improve, aid or enhance state regulation and that do not frustrate state policy or the role of a

commissioner are not pre-empted. Civil RICO should remain a viable remedy for policyholders.

ARGUMENT

Introduction

Petitioners assert that the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), precludes a private litigant from seeking the civil remedies available under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1964(c) (1994 & Supp. I 1995), where the lawsuit alleges fraudulent conduct by an insurer. Specifically, petitioners allege application of RICO "invalidates, impairs, or supersedes" state laws regulating the business of insurance where the state and federal statutory prohibitions are parallel, but the remedies provided are materially different.

The NAIC, and its members, believe strongly that the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, does not bar a federal civil RICO action by policyholders. While the NAIC believes States are entitled, pursuant to the McCarran-Ferguson Act, to enact legislation that would pre-empt civil RICO actions, neither Nevada, nor other States of which the NAIC is aware, has chosen to make its version of the NAIC's model Unfair Trade Practices Act[7]

[7] The 1989 text of the NAIC's model Unfair Trade Practices Act, which closely resembles Nevada's Trade Practices and Frauds, NEV. REV. STAT. Title 57 §§ 686A.010 to 686A.310 (1997), is reprinted in the Appendix.

the sole and exclusive remedy under state law for policyholders alleging fraud and misrepresentation by an insurer.

I. CONGRESS DID NOT INTEND THE MCCARRAN-FERGUSON ACT TO PRE-EMPT THE FIELD OF INSURANCE REGULATION. ONLY FEDERAL STATUTES THAT INVALIDATE, IMPAIR OR SUPERSEDE SPECIFIC STATE INSURANCE LAWS ARE PRE-EMPTED

Petitioners argue that Congress, by enactment of the McCarran-Ferguson Act, voluntarily "[withdrew] from a field seen best left to the states." Pet. Brief p. 9. Petitioners state the "language and history of the statute * * * intended to withdraw Congress from the field absent an express congressional statement to the contrary." Pet. Brief p. 10. "Field" pre-emption, as that term is generally understood, is inappropriate as the test for determining the application of the McCarran-Ferguson Act. There are federal statutes, however, that improve, aid and enhance the state regulatory system. Section 2(b) of the Act provides:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance * * * unless such Act specifically relates to the business of insurance.

15 U.S.C. § 1012(b).[8] A plain reading of this passage does not indicate field pre-emption. As stated in *Merchants*

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[8] All parties agree that civil RICO does not "specifically relate" to the business of insurance. "Indeed, virtually every court considering this issue has held that RICO is not a federal statute exempt from the McCarran-Ferguson Act." *Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185, 192 (3d Cir. 1997), petition for cert. filed, 67 U.S.L.W. 3024 (June 29, 1998).

Home Delivery Serv., Inc. v. Frank B. Hall & Co., 50 F.3d 1486 (9th Cir.), *cert. denied*, 516 U.S. 964 (1995):

> We adopt the Seventh Circuit's well-reasoned approach. The language of § 2(b) is inconsistent with a congressional intent to allow states to pre-empt the field of insurance regulation. First, § 2(b)'s exemption of federal laws which specifically relate to the business of insurance weighs against a congressional intent wholly to abandon the field to the states. Second, only federal statutes which "invalidate, impair, or supersede" state insurance statutes are "preempted." If Congress had intended to cede the field, it could have said: "No federal statute shall be construed to *apply* to the business of insurance."

Erroneously believing field pre-emption to be the test, petitioners have vaguely put forth specific Nevada insurance laws that they allege RICO affects or displaces. Petitioners cite to §§ 686A.020, 686A.030 and 686A.040 as evidence of an intent by the Nevada legislature that RICO remedies do not apply to the conduct here. Pet. Brief p. 24. Petitioners cite § 686A.310 in footnote 4 contained within the Statement of the Facts. Pet. Brief p. 7. Since the lower district court appeared to rely on, in part, Nevada's Trade Practices and Fraud provisions, this brief will assume the Petitioners believe that civil RICO invalidates, impairs, or supersedes NEV. REV. STAT. Title 57 §§ 686A.010 to 686A.310. "In order to determine whether a cause of action under RICO would 'invalidate, impair,

or supersede' * * * insurance law, we must initially juxtapose RICO with a specific state law enacted for the purpose of regulating the insurance business." *Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185, 192 (3d Cir. 1997), petition for cert. filed, 67 U.S.L.W. 3024 (June 29, 1998). *See also Mackey v. Nationwide Ins. Co.*, 724 F.2d 419, 421 (4th Cir. 1984) ("the presence of a general regulatory scheme" addressing insurance "does not show that any particular state law would be invalidated, impaired, or superseded.")

II. THE NAIC'S MODEL UNFAIR TRADE PRACTICES ACT AND NEVADA'S LAWS REGARDING TRADE PRACTICES AND FRAUDS DO NOT EXTINGUISH PRIVATE RIGHTS OF ACTION SUCH AS CIVIL RICO

Nevada's laws regarding Trade Practices and Frauds are substantially derived from the NAIC's model Unfair Trade Practices Act (Model Act). The Model Act was adopted by the NAIC in 1947 in direct response to passage of the McCarran-Ferguson Act. The Model Act was patterned very closely after the Federal Trade Commission Act (FTC Act) existing at that time, and only varied by enumerating certain defined acts or practices peculiar to the business of insurance. Enforcement provisions were made similar. The commissioners were given the authority to examine and investigate, conduct hearings and issue cease and desist orders, which were subject to judicial review. Even the Model Act's original penalty provisions were identical to the FTC Act.

The express purpose for effectively duplicating the FTC Act was to prevent the application of the FTC Act to the business of insurance. The "Purpose" section of the Model Act recites this fact. Because of the broad language of the FTC Act, it was necessary that state statutes should substantially cover the same ground as the FTC Act. Otherwise, a gap might result in the authority of the State which might leave these insurance practices under the jurisdiction of the FTC.[9]

In duplicating the provisions of the FTC Act, the NAIC also explicitly sought not to interfere with or disrupt existing private party causes of action, nor to create new private rights of action. In "A Report of Director Robert Ratchford, Jr., of Ohio, Regarding a Private Right of Action Under Section 4(9) [or any other section] of the NAIC Model Unfair Trade Practices Act," *NAIC Proceedings* 1980, Vol. II. p. 344 at 350, it states:

> * * * the intent of the NAIC, as evidenced in the language of the Model and the *NAIC Proceedings*, and supplemented by this Report, was clearly not to create a new private right of action for trade practices which are prohibited by the Model Act. *Any such practices which may be actionable under other law are not restricted by the Model.*[10] (emphasis added).

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[9] *NAIC Proceedings* 1959, Vol. I. p. 145-147.

[10] *See, NAIC Proceedings* 1980, Vol. II. p. 344 at 345. The Report also stated: "The FTC Act, and orders issued under it, has been held by the U.S. Supreme Court as not 'intended to impose criminal punishment or exact compensatory damages for past acts but to prevent illegal practices in the future.' *FTC v. Ruberoid Co.*, 78 S. Ct. 800 at p. 803 (1952). I know of no case in

As further evidence that the Model Act was never intended to create or extinguish private rights of action, in the early 1970s, the NAIC considered amendments to the Model Act to expand commissioners' remedial options and to address unfair insurance claims settlement practices. One proposal would have allowed commissioners to bring class actions on behalf of injured consumers for relief from unfair practices. Another would have expanded the remedies available to commissioners, once an unfair practice had been demonstrated, and to include orders directing the guilty party to make restitution to those injured by its practices. On November 29, 1971, an Industry Advisory Committee successfully argued against the inclusion of so-called "restitution" provisions in any revisions to the Model Act contending that such remedies were unnecessary because "persons injured have an adequate remedy at law," and that it was inappropriate to have the commissioner assume "a role that is usually the province of a jury – that is, ascertain who may have been harmed and by what extent." *NAIC Proceedings* 1972, Vol. I. p. 490 at 509.[11]

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which the courts have held that the FTC Act itself creates a private right of action in the person alleged to be injured as a result of the commission of the unfair act or practice. Given that the 1947 Model Act was specifically designed to foreclose the application of the FTC Act to insurance practices; and that the Model so closely parallels the FTC Act; and that in the absence of any evidence to the contrary, *we must conclude that the 1947 Model act was never intended to go beyond the FTC Act and did not itself create any private right of action.*" (emphasis added).

[11] Over the years, many state legislatures have provided commissioners with the power to compel restitution for aggrieved policyholders; however, the NAIC is unaware of any

The petitioners' argument, that Nevada's Trade Practices and Fraud statutes are such a comprehensive regulatory scheme that they would supersede private party remedies is flatly contradicted by both the text and the legislative history of those statutes. Nothing in the debates surrounding the Model Act in 1947, 1959, 1971, 1990, or since, suggest that the drafters meant to foreclose enforcement of *any* private remedies for insurer fraud or misrepresentation, whether state or federal.

Case law in Nevada supports the conclusion that its laws regarding Trade Practices and Frauds were not intended to invalidate, impair or supersede any private remedies, except to enhance or complement them. The seminal case in Nevada recognizing a common-law remedy for bad faith against an insurer is *United States Fidelity & Guaranty Co. v. Peterson*, 540 P.2d 1070 (1975). In that case, the Nevada Supreme Court first recognized the existence of a cause of action for an insurer's tortious breach of the implied covenant of good faith and fair dealing. *Peterson* involved a claim made by the insurer's own insured, i.e., a "first party" claim. The court found that an insurer engaged in bad faith where it acted unreasonably by refusing to pay monies validly due under an

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states that preclude additional private remedies to policyholders. *See also NAIC Proceedings* 1971, Vol. II. p. 344 at 350. On June 16, 1971, the Industry Advisory Committee provided a similar report that "strongly recommends against the inclusion in the Model Act of any provision for consumer class action suits for damages resulting from violation of the Act * * * *[because] the common law in all states recognize the principle of representative actions, so the consumer is not without remedy in this area.*" (emphasis added).

insurance contract, where the insurer was aware of the precarious financial condition of the insured. In *Peterson*, the court never mentions the Nevada Trade Practices and Frauds laws, and explicitly states that the duty is one "imposed by law." *Id.* at 1071.

In 1987, the Nevada legislature amended § 686A.310 to include, for the first time, a private right of action:

> 2. In addition to any rights or remedies available to the commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.

In *Hart v. Prudential Prop. & Cas. Ins. Co.*, 848 F.Supp. 900 (D.Nev. 1994), the court described the inter-relationship between the common law tort of bad faith as recognized in *Peterson, supra*, and Nevada's laws regarding Trade Practices and Frauds, and in particular, the new private right of action in § 686A.310(2). In doing so, the court held that it was not the intent of the Nevada legislature in enacting the §§ 686A.010 to 686A.310 to codify the common bad faith tort. Rather, § 686A.310(2) is intended as an additional remedy at law available to aggrieved first party insureds. *Id.* at 900.

III. CIVIL RICO IMPROVES, AIDS, COMPLEMENTS AND ENHANCES STATE REGULATION OF THE BUSINESS OF INSURANCE AND IS USED BY COMMISSIONERS TO FIGHT FRAUD

The job of an insurance commissioner is complex. Operating primarily in an administrative law setting, a commissioner's duties commonly include ensuring the

solvency of insurance companies doing business in the state, licensing of those companies and their agents and brokers, review and approval of rates and policy forms, performing financial and market conduct examinations, overseeing insurance company restructuring activities, liquidations and receiverships, among other activities. Each commissioner is also responsible for enforcement actions against illegal or unethical conduct of certain entities for a variety of proscribed statutory and regulatory behavior.

It is within the context of these heavy responsibilities that the drafters of the NAIC's model Unfair Trade Practices Act and the state legislators who enacted substantially similar state laws, have carefully avoided placing the commissioner in the role of protector and pursuer of the private rights of action of those injured by insurance-related frauds and misrepresentations. To the contrary, where retrospective remedies for private victims of insurance fraud are concerned, state legislatures have left the responsibility of seeking advantage of existing state, or here, federal, remedies to the victim. It would not be realistic to expect insurance commissioners to settle every dispute among policyholders, insurers, brokers, agents, intermediaries, reinsurers, and the like, and it would make no economic or common sense to try to reinvent the whole structure of contractual and tort remedies in the guise of insurance regulation.[12]

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[12] For a complete review of existing policyholder private rights of action, *see* "Liability of Insurer for Penalties and Attorney's Fees," *Couch on Insurance* 2d (Rev. ed.) § 58.

In RICO, Congress created a whole new vehicle for pursuing recompense for certain serious frauds, including certain frauds perpetrated in connection with insurance activities. And, it is an appealing vehicle with its provisions for treble damages, attorneys' fees to prevailing parties, interstate service of summons, and its generous statute of limitations. In the over 28 years since RICO was enacted, not a single commissioner has complained that RICO was interfering with the enforcement of any state insurance law. To the contrary, certain commissioners gave Congressional testimony against efforts to weaken RICO,[13] and the NAIC filed an *amicus* brief urging a broad construction of the "participation" element of a RICO violation in the Supreme Court appeal of *Reves v. Ernst & Young*, 113 S. Ct. 1163 (1993). In addition, commissioners have themselves successfully used RICO where, by operation of their responsibilities under insurance liquidation codes, they are required to pursue private actions on behalf of insolvent insurance companies that were defrauded by those who operated them.

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[13] The testimony was given in 1989 in connection with S. 438 and in 1991 in connection with H.R. 1717. Neither bill passed.

IV. THE MCCARRAN-FERGUSON ACT BROADLY PRE-EMPTS FEDERAL STATUTES SO AS TO PROTECT STATES' RIGHT TO REGULATE THE BUSINESS OF INSURANCE. CIVIL RICO IS NOT PRE-EMPTED BECAUSE IT IMPROVES, AIDS AND ENHANCES THE STATE REGULATORY SYSTEM

In passing the McCarran-Ferguson Act, Congress intended to give *broad* support to existing and future state systems for regulating the business of insurance. As this Court stated in *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429-430 (1946):

> This was done * * * by removing obstructions which might be thought to flow from its own power, whether dormant or exercised * * * [and] by declaring expressly and affirmatively that continued state regulation * * * is in the public interest. * * * its purpose was evidently to throw the whole weight of its power behind the state systems * * * .

This broad support for McCarran-Ferguson pre-emption was again stated in the Court's pronouncement in *U.S. Dept. of the Treasury v. Fabe*, 508 U.S. 491, 505-507 (1993):

> The broad category of laws enacted "for the purpose of regulating the business of insurance" consists of laws that possess the "end, intention, or aim" of adjusting, managing, or controlling the business of insurance. * * * This category necessarily encompasses more than just the "business of insurance." * * * The McCarran-Ferguson Act did not simply overrule *South-Eastern Underwriters* and restore the status quo. To the contrary, it transformed the legal landscape by overturning the normal rules of

> pre-emption. * * * The first clause of § 2(b) * * * imposes what is, in effect, a clear-statement rule, a rule that state laws enacted "for the purpose of regulating the business of insurance" do not yield to *conflicting* federal statutes unless a federal statute specifically requires otherwise. (emphasis added.)

McCarran-Ferguson requires that the test for this "conflict" is when a federal statute "invalidates, impairs, or supersedes" a state law regulating the business of insurance. When one attempts to simplify the many dictionary meanings for such terms (e.g., to weaken, to destroy the authority of, to make worse, to deteriorate, to force out as inferior, to replace) one is left with a resounding conclusion – federal statutes that improve, aid or enhance the regulatory system that state legislatures have enacted are not pre-empted. Federal statutes that do not frustrate state policy, or the role of a commissioner under that policy, are not pre-empted.

Cases such as *Silkwood*[14] and *ARC America*[15] decided that state and federal rules that are substantively identical but differ in penalty do not conflict with or displace each other. Nothing in this conclusion permits federal law to displace States' choices about the proper conduct of the business of insurance. *N.A.A.C.P. v. American Family Mut. Ins. Co.*, 978 F.2d 287 (7th Cir. 1992), *cert. denied*, 508 U.S. 907 (1993).

Unless and until a State chooses to design laws or remedies for aggrieved policyholders that would be

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[14] *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238 (1984).

[15] *California v. ARC America Corp.*, 490 U.S. 93 (1989).

harmed or adversely affected directly or indirectly, civil RICO should remain a viable option in their arsenal of existing administrative and judicial remedies available under the law.

CONCLUSION

For all these reasons, the NAIC respectfully urges that the Court affirm the decision of the Court of Appeals.

Respectfully submitted,

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UNFAIR TRADE PRACTICES ACT

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Section 1. Declaration of Purpose.

The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Section 2. Definitions.

When used in this Act:

A. "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, consultants and adjusters. Person shall also mean medical service plans and hospital service plans as defined in Section [insert applicable section]. For purposes of this Act, medical and hospital service plans shall be deemed to be engaged in the business of insurance.

Drafting Note: Consultant is defined in the Agents and Brokers Licensing Model Act, Page 210-2, as follows:

Section 2. Definitions

E. Consultant. A consultant is an individual, partnership or corporation, who, for a fee, holds himself or itself out to the public as engaged in the business of offering any advice, counsel, opinion or service with

respect to the benefits, advantages or disadvantages promised under any policy of insurance that could be issued in this State.

Each state should examine its laws respecting insurance consultants or financial planners to determine if this section conflicts with existing laws.

Drafting Note: This definition could also include dental, optometric and other service plans The enabling statutes of all service plans should also be amended to make them subject to this Act.

B. "Commissioner" shall mean the Commissioner of Insurance of this state.

C. "Insurance policy" or "insurance contract" shall mean any contact of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any person.

Drafting Note: Each state may wish to consider the advisability of defining "insurance" for purposes of this Act if its present insurance code is not satisfactory in this regard. In some cases a cross reference will be sufficient. "Service contract" is intended to cover the product issued by medical and hospital service plans and should be changed to conform to the laws of each state.

Section 3. Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Prohibited.

No person shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to Section 7 of this Act to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Section 4. Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

A. Misrepresentations and False Advertising of Insurance Policies. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustrations, circular or statement, sales presentation, omission, or comparison which:

(1) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; or

(2) Misrepresents the dividends or share of the surplus to be received on any insurance policy; or

(3) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; or

(4) Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; or

(5) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; or

(6) Is a misrepresentation for the purpose of inducing or tending to induce to the lapse, forfeiture, exchange, conversion or surrender of any insurance policy; or

(7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(8) Misrepresents any insurance policy as being shares of stock.

B. False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

C. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

D. Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

E. False Statements and Entries.

(1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering

to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(2) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

F. Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

G. Unfair Discrimination.

(1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder,

or in any of the terms or conditions of such contract, or in any other manner whatever.

Drafting Note: In the event that unfair discrimination in connection with accident and health coverage is treated in other statutes, this paragraph should be omitted.

(3) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(a) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(b) The refusal, cancellation or limitation is required by law or regulatory mandate.

(4) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

(a) The refusal, cancellation or limitation is for a business purpose which is not a mere pretext for unfair discrimination, or

(b) The refusal, cancellation or limitation is required by law or regulatory mandate.

(5) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex or marital status of the individual; however, nothing in

this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits.

(6) To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is either mentally or physically impaired; provided that this subsection shall not apply to accident and health insurance sold by a casualty insurer and, provided further, that this subsection shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract.

H. Rebates.

(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity, or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association

or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(2) Nothing in Subsection G, or Paragraph (1) of Subsection H shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an, office of the insurer in an amount which fairly represents the saving in collection expenses;

(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

Drafting Note: Each state may wish to examine its rating laws to assure that they contain sufficient provision against rebating. If they do not, this section might be expanded to cover all lines of insurance.

I. Unfair Claim Settlement Practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(10) Making claims payments to the insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments an being made;

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) Failing to promptly settle claims, when liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

J. Failure to Maintain Complaint Handling Procedures. Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination under Section [insert applicable section].

This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.

Drafting Note: Each state may wish to consider exempting agents and brokers from this subsection.

K. Misrepresentation in Insurance Applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurers, agent, broker or individual.

L. Unfair Financial Planning Practices. An insurance agent, broker or consultant:

(1) Holding himself out, directly or indirectly, to the public as a "financial planner," "investment adviser," "consultant," "financial counselor," or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters when such person is in fact engaged only in the sale of insurance contracts.

This provision is not intended to preclude persons who hold some form of formal recognized financial planning or consultant designation from using this designation when they are only selling insurance. This does not permit individuals to charge an additional fee for services which are customarily associated with the solicitation, negotiation or servicing of an insurance contract.

(2)(a) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Paragraph 3, or solicitation of the sale of a product or service that

(i) He is also an insurance salesperson, and

(ii) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(b) The disclosure requirement under this subsection may be met by including it in any disclosure required by federal or state securities law,

(3)(a) Charging fees other than commissions for financial planning by insurance agents, brokers or consultants, unless such fees are based upon a written agreement, which is signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party.

(i) The services for which the fee is to be charged must be specifically stated in the agreement.

(ii) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(iii) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance agent, broker or consultant.

Drafting Note: This subsection is intended to apply only to persons engaged in personal financial planning.

(b) The insurance agent, broker or consultant must retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the Commissioner upon request.

M. Any violation of any one of Sections [insert applicable sections].

Drafting Note: Insert section numbers of any other sections of the insurance law which it is deemed desirable or necessary to include as an unfair trade practice.

Section 5. Favored Agent or Insurer; Coercion of Debtors.

A. No person may require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any contract of insurance or renewal thereof through a particular insurer or group of insurers or agent or broker or group of agents or brokers.

B. No person who lends money or extends credit may:

(1) Solicit insurance for the protection of real property, after a person indicates interest in securing a first mortgage credit extension, until

such person has received a commitment in writing from the lender as to a loan or credit extension;

(2) Unreasonably reject a contract of insurance furnished by the borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, not shall such standards call for rejection of an insurance contract because the contract contains coverage in addition to that required in the credit transaction;

(3) Require that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge, in connection with the handling of any contract of insurance required as security for a loan on real estate, or pay a separate charge to substitute the insurance policy of one insurer for that of another. This paragraph does not include the interest which may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document;

(4) Use or disclose, without the prior written consent of the borrower, mortgagor or purchaser taken at a time other than the making of the loan or extension of credit, information relative to a contract of insurance which is required by the credit transaction, for the purpose of replacing such insurance;

(5) Require any procedures or conditions of duly licensed agents, brokers, or insurers not customarily required of those agents, brokers or

insurers affiliated or in any way connected with the person who lends money or extends credit.

C. Every person who lends money or extends credit and who solicits insurance on real and personal property subject to Subsection B of this section must explain to the borrower in writing that the insurance related to such credit extension may be purchased from an insurer or agent of the borrower's choice, subject only to the lender's right to reject a given insurer or agent as provided in Subsection B(2). Compliance with disclosures as to insurance required by Truth-In-Lending laws or comparable state laws shall be in compliance with this subsection.

This requirement for a commitment shall not apply in cases where the premium for the required insurance is to be financed as part of the loan or extension of credit involving personal property transactions.

D. The Commissioner shall have the power to examine and investigate those insurance related activities of any person which the Commissioner believes may be in violation of this section. Any affected person may submit to the Commissioner a complaint or material pertinent to the enforcement of this section.

E. Nothing herein shall prevent a person who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

F. Nothing contained in this section shall apply to credit life or credit accident and health insurance.

G. For purposes of this section, "person" includes any individual, corporation, association, partnership or other legal entity.

Section 6. Power of Commissioner.

The Commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 3 of this Act.

Section 7. Defined and Undefined Practices: Hearings, Witnesses, Appearances, Production of Books, and Service of Process.

A. Whenever the Commissioner shall have reason to believe that any person, as defined in Section 2A or Section 5G, has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in Section 4 or 5, and that a proceeding by him in respect thereto would be to the interest of the public, he shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than [insert number] days after the date of the service thereof.

B. At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the Commissioner requiring such person to cease and desist from the

acts, methods or practices so complained of. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

C. Nothing contained in this Act shall require the observance at any such hearing of formal rules of pleading or evidence.

D. The Commissioner, upon such hearing, may administer oaths, examine and cross examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. The Commissioner, upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the Commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the [insert title] Court of [insert county] County or the county where such party resides, on application of the Commissioner, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

E. Statements of charges, notices, orders, and other processes of the Commissioner under this Act may be served

by anyone duly authorized by the Commissioner, either in the manner provided by law for service of process in civil actions, or by registering and mailing a copy thereof to the person affected by such statement, notice, order, or other process at his or its residence or principal office or place of business. The verified return, by the person so serving such statement, notice, order, or other process, setting forth the manner of such service, shall be proof of the same, and the return, postcard receipt for such statement, notice, order or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

Section 8. Cease and Desist and Penalty Orders and Modifications Thereof.

A. If, after such hearing, the Commissioner shall determine that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of Sections 4 or 5, the Commissioner may at his discretion order any one or more of the following:

(1) Payment of a monetary penalty of not more than $1,000 for each and every act or violation but not to exceed an aggregate penalty of $10,000 unless the person knew or reasonably should have known he was in violation of this Act, in which case the penalty shall be not more

than $5,000 for each and every act or violation but not to exceed an aggregate penalty of $50,000 in any six-month period.

(2) Suspension or revocation of the person's license if he knew or reasonably should have known he was in violation of this Act.

B. Until the expiration of the time allowed under Section 9 of this Act for filing a petition for review (by appeal or writ of certiorari) if no such petition has been duly filed within such time or, if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the [insert title] Court, as hereinafter provided, the Commissioner may at any time, upon such notice and in such manner as he shall deem proper, modify or set aside in whole or in part any order issued by him under this section.

C. After the expiration of the time allowed for filing such a petition for review if no such petition has been duly filed within such time, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify or set aside, in whole or in part, any order issued by him under this section, whenever in his opinion conditions of fact or of law have so changed as to require such action or if the public interest shall so require.

Section 9. Judicial Review of Orders.

A. Any person subject to an order of the Commissioner under Section 8 or Section 11 may obtain a review of such order by filing in the [insert title] Court of [insert county] County, within [insert number] days from the date of the

service of such order, a written petition praying that the order of the Commissioner be set aside. A copy of such petition shall be forthwith served upon the Commissioner, and thereupon the Commissioner forthwith shall certify and file in such court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the Commissioner. Upon such filing of the petition and transcript such court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of such petition shall operate as a stay of such order of the Commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in such transcript a decree modifying, affirming or reversing the order of the Commissioner, in whole or in part. The findings of the Commissioner as to the facts, if supported by [insert type] evidence, shall be conclusive.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the Commissioner's determination.

B. To the extent that the order of the Commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of such order of the Commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the Commissioner, the court may order such additional evidence to be taken before the Commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper.

The Commissioner may modify his findings of fact, or make new findings by reason of the additional evidence so taken, and he shall file such modified or new findings which is supported by [insert type] evidence shall be conclusive, and his recommendation if any, for the modification or setting aside of his original order, with the return of such additional evidence.

Drafting Note: Insert appropriate language to accommodate to local procedure the effect given the Commissioner's determination. In a state where final judgment, order or decree would not be subject to review by an appellate court provision therefor should be here inserted.

C. An order issued by the Commissioner under Section 8 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the Commissioner may thereafter modify or set aside his order to the extent provided in Section 8B; or

(2) Upon the final decision of the court if the court directs that the order of the Commissioner be affirmed or the petition for review dismissed.

D. No order of the Commissioner under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Section 10. Judicial Review by Intervenor.

If after any hearing under Section 7 or Section 11, the report of the Commissioner does not charge a violation of

this Act, then any intervenor in the proceedings may within [insert number] days after the service of such report, cause a petition [notice of appeal] [petition for writ of certiorari] to be filed in the [insert title] Court of [insert county] County for a review of such report. Upon such review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act or practice which it finds, notwithstanding such report of the Commissioner, constitutes a violation of this Act, and containing penalties pursuant to Section 8.

Drafting Note: The type of procedure should conform to state procedure. See also note to Section 9 concerning review of appellate courts.

Section 11. Penalty for Violation of Cease and Desist Orders.

Any person who violates a cease and desist order of the Commissioner under Section 8 and while such order is in effect may after notice and hearing and upon order of the Commissioner be subject at the discretion of the Commissioner to any one or more of the following:

A. A monetary penalty of not more than $10,000 for each and every act or violation; or

B. Suspension or revocation of such person's license.

Section 12. Regulations.

The Commissioner may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by Sections 4 or 5, but the regulations shall not enlarge upon or extend the provisions of Sections 4 and 5. Such regulations shall be subject to review in accordance with Section [insert applicable section].

Drafting Note: Insert section number providing for review of administrative orders.

Section 13. Provisions of Act Additional to Existing Law.

The powers vested in the Commissioner by this Act, shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

Section 14. Immunity From Prosecution.

If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture, and shall notwithstanding be directed to give such testimony or produce such evidence, he must none the less comply with such direction, but he shall not thereafter be prosecuted or subjected to any penalty or

forfeiture for or on account of any transaction, matter or thing concerning which he may testify or produce evidence thereto, and no testimony so given or evidence produced shall be received against him upon any criminal action, investigation or proceeding, provided, however, that no such individual so testifying shall be exempt from prosecution or punishment for any perjury committed by him while so testifying and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation or proceeding concerning such perjury nor shall he be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Law of this state. Any such individual may execute, acknowledge and file in the office of the Commissioner a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement and thereupon the testimony of such person or such evidence in relation to such transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privilege on account of any testimony he may so give or evidence so produced.

Section 15. Separability Provision.

If any provision of this Act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to person or circumstances other than

those as to which it is held invalid, shall not be affected thereby.

Legislative History (all references are to the proceedings of the NAIC).

1947 Proc. 383, 392-400, 413 (adopted).
1960 Proc. II 485-487, 509-515, 516 (reprinted).
1972 Proc. I 15, 16, 443-444, 491, 493-501 (amended and reprinted).
1977 Proc. I 26, 28, 211, 226-227 (amended).
1979 Proc. II 31, 34, 38, 39, 525 (amended).
1985 Proc. I 19, 39, 85-86 (amended).
1989 Proc. II 13, 21, 129-130, 132, 133-140 (amended and reprinted).

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No. 97-303

IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

HUMANA INC. and HUMANA HEALTH INSURANCE OF NEVADA, INC.,
Petitioners,

v.

MARY FORSYTH, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF *AMICUS CURIAE* THE NATIONAL FAIR HOUSING ALLIANCE IN SUPPORT OF RESPONDENTS

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

No. 97-303

HUMANA INC. and HUMANA HEALTH INSURANCE OF NEVADA, INC.,

Petitioners,

v.

MARY FORSYTH, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

BRIEF OF *AMICUS CURIAE* THE NATIONAL FAIR HOUSING ALLIANCE IN SUPPORT OF RESPONDENTS

The National Fair Housing Alliance, as *amicus curiae*, suggests that the judgment and opinion of the United States Court of Appeals for the Ninth Circuit entered in this proceeding on May 23, 1997 be affirmed.[1]

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[1] Pursuant to Rule 37.6 of the Rules of the Supreme Court, *amicus* states that no counsel for a party has authored any part of this brief, and no person or entity, other than the *amicus*, its members, or its counsel, made any monetary contribution to the preparation or submission of this brief.

INTERESTS OF THE *AMICUS CURIAE*

The National Fair Housing Alliance, Inc. (NFHA) is a non-profit corporation that represents private fair housing centers throughout the United States. NFHA's purpose is the achievement of "the policy of the United States to provide, within constitutional limitations, for fair housing throughout the United States." It attempts to fulfill that purpose by conducting research into the nature and effects of housing discrimination, advocating for effective programs of fair housing compliance enforcement, sponsoring national education conferences on fair housing issues and fair housing litigation, and participating in fair housing cases as a litigant. NFHA also attempts to identify and eliminate housing practices that are discriminatory and that constitute barriers to equal access to housing.

NFHA has a direct interest in the application of statutes prohibiting discrimination in housing, including discrimination by homeowners insurers. To that end, NFHA seeks leave to participate as *amicus curiae* in those cases that interpret the laws of the United States as they affect fair housing. In this case, the interpretation of the McCarran-Ferguson Act advocated by the petitioners as grounds for reversal of the Court of Appeals for the Ninth Circuit has important implications for the enforcement of federal statutes that affect fair housing, including the Fair Housing Act and the Truth in Lending Act.

Petitioners and respondents have consented to this *amicus curiae* brief. Copies of the letters granting consent have been filed with the Clerk.

SUMMARY OF ARGUMENT

Petitioners urge the Court to interpret the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, to bar suit against an insurance company because the remedies available under the federal statute upon which the suit is based differ from those available under Nevada's insurance laws. Federal statutes often include remedies, such as

private rights of action, punitive damages, and awards of attorneys' fees to the prevailing party, that are not available under state insurance codes. This Court has held that private actions are essential to the enforcement of many federal statutes, including civil rights laws. Under petitioners' suggested interpretation of the McCarran-Ferguson Act, however, such actions against insurers would be barred unless a state's insurance code happened to allow them. Petitioners' interpretation conflicts with the Act itself, which specifically allows federal antitrust suits against insurers, even though the antitrust laws include remedies that are not available under state insurance law. Moreover, without evidence of a reasoned state policy of exclusive administrative enforcement, it would be a pointless act of imagined deference to apply the Act out of concern for the effect that suits under federal law may have on the state administrative process.

ARGUMENT

THE McCARRAN-FERGUSON ACT DOES NOT APPLY TO BAR SUIT UNDER A FEDERAL STATUTE UNLESS THERE IS A DIRECT SUBSTANTIVE CONFLICT OR THE PURPOSE OR EFFECT OF THE FEDERAL LAW IS PRIMARILY TO REGULATE THE BUSINESS OF INSURANCE.

In this lawsuit, the Court is asked to determine whether the McCarran-Ferguson Act bars enforcement of the Racketeer Influenced and Corrupt Organizations Act ("RICO") against an insurance company. Petitioners do not argue that there is any conflict in the *substance* of the law applied to the insurer: RICO and Nevada law each forbid the same actions. Indeed, it is well established that if there is a direct conflict in substantive law, the McCarran-Ferguson Act will prevent the federal law from being enforced.[2] Rather, petitioners argue that the

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[2] *See Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 463 (1969).

differences in *remedies* available under RICO are sufficient to "invalidate, impair, or supersede" Nevada insurance law, thus raising the McCarran-Ferguson Act's bar to enforcement of the federal statute.[3]

Many states have codes to regulate the activities of insurers, codes that often provide only for administrative enforcement.[4] When sued for violating general federal statutes, such as the Fair Housing Act or the Truth in Lending Act, insurers often raise those state codes as a defense, arguing that the remedies available under federal law, such as a private right of action, fee shifting, or punitive damages, will impermissibly "impair" the state's administrative scheme.[5] Until recently, no appeals court was persuaded: the circuits uniformly held that, in the

[3] The pertinent text of the Act, codified at 15 U.S.C. § 1012(b), states that:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.

[4] *See, e.g., N.A.A.C.P. v. American Family Mut. Ins. Co.*, 978 F.2d 287, 295 (7th Cir.), *cert. denied*, 508 U.S. 907 (1993) (Wisconsin insurance code does not create a private right of action); *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486, 1491 (9th Cir.), *cert. denied*, 516 U.S. 964 (1995) (California insurance code allows only administrative enforcement); *Nationwide Mut. Ins. Co. v. Cisneros*, 52 F.3d 1351, 1363 (6th Cir.), *cert. denied*, 516 U.S. 1140 (1996) (Ohio insurance code does not afford a private right of action).

[5] *See, e.g., Nationwide Mut. Ins. Co. v. Cisneros*, 52 F.3d 1351, 1363 (6th Cir.), *cert. denied*, 516 U.S. 1140 (1996) (insurer argued that the availability of private civil actions, jury trials, and unlimited punitive damages under the Fair Housing Act would impair or supersede Ohio insurance law); *Edwards v. Your Credit, Inc.*, 148 F.3d 427, 432-35 (5th Cir. 1998) (insurer argued that the availability of a private right of action under the Truth in Lending Act would impair or supersede Louisiana insurance law).

absence of a direct substantive conflict, federal and state law remedies could co-exist.[6]

Now, however, one appeals court has deemed a difference in remedial provisions to be sufficient reason to trigger McCarran-Ferguson. Upholding the dismissal of a RICO claim, the Eighth Circuit opined that "the possibility of treble damages and attorney fees [under RICO] would eviscerate the administrative system by diverting any rational aggrieved policyholder from the [state Insurance] Commissioner's office to federal court." *Doe v. Norwest Bank Minnesota, N.A.*, 107 F.3d 1297, 1306 (8th Cir. 1997).[7] Petitioners argue that this reasoning should be applied to the case against them, too.

Although the issue, as narrowly framed for decision, seems only to involve RICO and the effect of its treble damages and attorney fee awards on state insurance law, the ramifications of this Court's decision will spread much more widely. Private civil suits are essential to the enforcement of many federal laws, as this Court has often recognized.[8] But if private suits under federal law "im-

[6] *See, e.g., N.A.A.C.P. v. American Family Mut. Ins. Co.*, 978 F.2d 287, 296 (7th Cir.), *cert. denied*, 508 US. 907 (1993); *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486, 1492 (9th Cir.), *cert. denied*, 516 U.S. 964 (1995); *Nationwide Mut. Ins. Co. v. Cisneros*, 52 F.3d 1351, 1363 (6th Cir.), *cert. denied*, 516 U.S. 1140 (1996); *Villafane-Neriz v. F.D.I.C.*, 75 F.3d 727, 736 (1st Cir. 1996); *Murff v. Professional Medical Ins. Co.*, 97 F.3d 289, 292 (8th Cir.), *cert. denied*, 117 S.Ct. 2452 (1997).

[7] In an unpublished *per curiam* opinion, the Court of Appeals for the Fourth Circuit indicated that it, too, viewed RICO's potential disruption of state administrative enforcement mechanisms as an "impairment" sufficient to trigger the McCarran-Ferguson Act's prohibition. *See Ambrose v. Blue Cross & Blue Shield of Virginia, Inc.*, 891 F. Supp. 1153, 1164-68 (E.D. Va.), *aff'd*, 95 F.3d 41 (4th Cir. 1996).

[8] *See, e.g., Basic Inc. v. Levinson*, 485 U.S. 224, 231 (1988) ("a private cause of action . . . constitutes an essential tool for enforcement of the 1934 [Securities Exchange] Act's requirements");

pair" state insurance regulation, as petitioners suggest they do, then enforcement of those national policies will be left to the limited resources and sometimes less-than-vigilant efforts of the state insurance commissioners.

Moreover, private enforcement is possible only because Congress has allowed remedies, such as attorney fee awards and punitive damages, in civil rights cases and other actions in which the amount of money damages at stake is small but the principles are vitally important. If those remedies are sufficient to raise the McCarran-Ferguson bar, then—as a practical matter—private enforcement of those federal laws against insurance companies will end, even if a private right of action is nominally available.[9]

When it passed the McCarran-Ferguson Act, Congress did not intend to limit its ability to make laws of general application apply to insurance companies.[10] Rather, it in-

Alyeska Pipeline Serv. Co. v. Wilderness Society, 421 U.S. 240, 263 (1975) ("Congress has opted to rely heavily on private enforcement to implement public policy"); *Alexander v. Gardner-Denver Co.*, 415 U.S. 36, 45 (1974) ("the private right of action remains an essential means of obtaining judicial enforcement of Title VII"); *Trafficante v. Metropolitan Life Ins. Co.*, 409 U.S. 205, 209 (1972) ("complaints by private persons are the primary method of obtaining compliance with the [Fair Housing] Act"); *Newman v. Piggie Park Enterprises, Inc.*, 390 U.S. 400, 402 (1968) (Congress allowed fee-shifting under Title II because a plaintiff who obtains relief in a civil rights lawsuit "does so not for himself alone but also as a 'private attorney general' ").

[9] Public enforcement by federal agencies would also be hampered. *Cf. Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 463 (1969) (insurer argued that remedy sought by Commission for securities fraud would "invalidate, impair, or supersede" Arizona's insurance laws).

[10] Had it so intended, it would have made the Act to read "No [Act of Congress] shall be construed to *apply* to the business of insurance." *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486, 1492 (9th Cir.), *cert. denied*, 516 U.S. 964 (1995).

tended to shield the states' ability to regulate insurers from inadvertent preemption by federal law. *See, e.g., U.S. Department of Treasury v. Fabe*, 508 U.S. 491, 499-500 (1993).[11] Accordingly, this Court has held that a federal law does not "invalidate, impair, or supersede" state insurance law unless there is either (1) a direct substantive conflict between them or (2) the purpose or effect of the federal law is primarily to regulate the business of insurance. *See Securities and Exchange Comm'n v. National Securities, Inc.*, 393 U.S. 453, 463 (1969).[12]

Petitioners urge the Court to broaden that test to encompass federal statutes that have remedies "materially different" than those available under state law. Such a departure is ill-advised, for three reasons. *First*, it does not comport with the McCarran-Ferguson Act itself, which specifically *allows* actions against insurers under federal antitrust laws. Those laws have remedies (such as treble damages) that differ materially from state-law administrative sanctions.[13] *Second*, as noted above, peti-

[11] The Court noted that "The first section of the McCarran-Ferguson Act makes its mission very clear: '. . . that silence on the part of Congress shall not be construed to impose any barrier to the regulation [of the business of insurance] by the several States.' " *Id.* at 500, *quoting* 15 U.S.C. § 1011.

[12] In *National Securities*, the Court upheld enforcement of a federal securities law that it deemed not to "affect a matter predominantly of concern to policyholders alone." *Id.* Matters that were predominantly of concern to policyholders alone, the Court determined, were "the business of insurance," which the McCarran-Ferguson Act left to state regulation absent an explicit statement by Congress. *Id.* at 460. The federal law at issue in *National Securities*, however, was "at least as important to those owning the companies' stock as it is to those holding their policies," and therefore not subject to the Act's bar. *Id.* at 463. By way of contrast, the Court noted that "if the Federal Government were attempting to regulate in the sphere reserved primarily to the States" by the Act (namely, the "business of insurance"), different questions about the Act's applicability would arise. *Id.*

[13] Under 15 U.S.C. § 1013(a), application of federal antitrust laws "to the business of insurance or to acts in the conduct thereof"

tioners' test would jeopardize the enforcement of many other federal statutes, such as the Fair Housing Act and the Truth in Lending Act, that also have remedies that differ from those available under state law. *Finally*, the mere fact that one set of remedies is available under a state's insurance laws does not prove that the state legislature intended those remedies to be exclusive.[14] Absent such proof, the application of McCarran-Ferguson to bar enforcement of a federal law—in imagined deference to state insurance regulation—would be a pointless but ironic act.

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was partially suspended until June 30, 1948. After expiration of this moratorium, however, Congress made clear that the antitrust laws would apply to the business of insurance "'to the extent that such business is not regulated by state law.'" *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 220 (1979), *quoting* 91 Cong. Rec. 1443 (remarks of Sen. Ferguson). Where appropriate, the antitrust laws have been applied to insurance companies. *See, e.g., Garot Anderson Marketing, Inc. v. Blue Cross and Blue Shield United of Wisconsin*, 772 F. Supp. 1054, 1063 (N.D. Ill. 1990) (Sherman Act); *American Family Life Assurance Co. v. Planned Marketing Assocs., Inc.*, 389 F. Supp. 1141, 1147 (E.D. Va. 1975) (Sherman and Clayton Acts).

[14] As the Court of Appeals for the Third Circuit recently observed, the mere absence of a private right of action under state insurance law does not indicate "a reasoned state policy of exclusive administrative enforcement." *Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185, 195 (3rd Cir. 1998).

CONCLUSION

For the reasons set forth above, the judgment and opinion of the United States Court of Appeals for the Ninth Circuit should be affirmed.

Respectfully submitted,

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OCTOBER TERM, 1998

HUMANA INC. AND HUMANA HEALTH INSURANCE OF NEVADA, INC.,

Petitioners,

v.

MARY FORSYTH, MARIETTA CADE, WILLIE ANDREWS, MARY LOU BUEHLER, HELEN STAVES, RANDOLPH BRATTON, AND SEARLE AUTO GLASS, INC.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF AMICI CURIAE

BETTY CORDIAL, DEPUTY RECEIVER OF GEORGE WASHINGTON LIFE INS. CO.;

ARNOLD DUTCHER, DIRECTOR OF INSURANCE FOR THE STATE OF ILLINOIS, IN HIS CAPACITY AS LIQUIDATOR OF INSOLVENT ILLINOIS INSURANCE COMPANIES; and

BARRY G. HITTNER, DIRECTOR OF THE RHODE ISLAND DEPARTMENT OF BUSINESS REGULATION, IN HIS CAPACITY AS RECEIVER OF AMERICAN AND CANADIAN UNIVERSAL INSURANCE COMPANIES

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INTEREST OF AMICI CURIAE[1]

Amici curiae are the statutory and court-appointed receivers of certain insolvent insurance companies. In this brief amici are referred to collectively as the "Receiver Amici." Some of the companies for which the Receiver Amici act failed because of unremarkable business reverses. Others, however, failed because persons in control illegally diverted policyholder premium dollars for their own personal use. Still others failed because those who operated them intentionally concealed their true financial condition from insurance regulators. Regardless of the cause of failure, however, the result was always the same: insurance consumers, who paid good dollars to purchase insurance coverage, were left essentially uninsured.

The Receiver Amici, of course, have no private, personal or economic stake in this review. In their capacity as fiduciaries for their estates, however, each amicus has a direct interest in the preservation of RICO, a powerful vehicle for the recovery of damages caused by misconduct that victimizes now-insolvent insurance companies. Each amicus has brought a civil RICO action against persons or entities whose criminal acts targeted an insolvent insurer. These actions have aimed to recover diverted assets and consequential damages. Amounts recovered have been added to the

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[1] The parties have consented to the filing of this brief. Copies of the letters of consent have been lodged with the Clerk of the Court. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than the amici curiae and their counsel, made a monetary contribution to the preparation and submission of this brief.

estate of the victimized insurer and eventually distributed to the insurer's policyholders and creditors.

Amicus Betty Cordial is the court-appointed receiver of George Washington Life Insurance Co., an insolvent West Virginia life insurer. Amicus Cordial brought a RICO action against the company's former officers, directors, accountants and attorneys, alleging they looted or aided in the looting of millions of policyholder premium dollars through sham subsidiaries and illegal dividends. Amicus Cordial recovered $7.3 million in pretrial settlements with the accountants and attorneys, and obtained a $13.6 million verdict against the directors and officers.[2]

Amicus Arnold Dutcher, Acting Director of Insurance for the State of Illinois, is the statutory liquidator of Reserve Insurance Company, ordered into liquidation in 1979, and numerous other insolvent insurers. The Liquidator of Reserve was plaintiff in a RICO action against the company's directors, officers, auditors and reinsurers. The Liquidator alleged that the defendants concealed the true financial condition of the company by acts of mail fraud, including the mailing of false financial statements, in which information about the company's liabilities and reinsurance was deliberately misstated. The Liquidator recovered $31 million in pretrial settlements in that action.[3]

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[2] The District Court decision upholding the legal sufficiency of the complaint is reported as *Clark v. Milam*, 872 F. Supp. 307 (S.D.W.Va. 1994).

[3] The Seventh Circuit's decision upholding the legal sufficiency of the complaint is reported as *Schacht v. Brown*, 711 F.2d 1343 (7th Cir. 1983).

Amicus Barry G. Hittner, Director of the Rhode Island Department of Business Regulation, appears in his capacity as Receiver of American and Canadian Universal Insurance Companies. These companies failed after they were looted by individuals who have now been criminally convicted for their misconduct. *United States v. Christopher*, 142 F.3d 46 (1st Cir. 1998), and *United States v. Reeder*, No. CR 93-41(02)B (D.R.I. June 27, 1997). Amicus Hittner has brought a civil RICO action against these looters and those who helped them obtain control of the companies.[4]

The Receiver Amici have found RICO to be an extraordinarily powerful weapon for vindicating their states' insurance regulatory goals by recovering damages for the benefit of the policyholders and creditors of insolvent insurers, and for punishing those whose illegal activities victimize insurance companies that are powerless to protect themselves from misconduct. Although in certain respects RICO parallels substantive state statutory or common law violations and remedies, RICO's provision for nationwide service of process has ensured receivers' ability to sue multiple wrongdoers in a single federal forum, a convenience that the states are simply powerless to provide. Further, RICO actions

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[4] Amicus Hittner's action, filed in the United States District Court of Rhode Island, was consolidated for discovery purposes with a RICO action by the receiver of an Arizona insurer that Christopher and Reeder also looted. (The action is now proceeding in the District Court in Arizona under the caption, *Hittner v. Sequa, et al.*, MDL 972, CIV-93-1035-PHX-RGS.) The District Court's memorandum opinion denying the defendants' motions to dismiss, issued March 28, 1995, is not reported, but copies have been lodged with the Court.

brought in the federal court have seemed, as a practical matter, to be greeted with heightened respect and concern by defendants, would-be defendants, and their chosen representatives.

For all these reasons, Receiver Amici have an interest in the issues raised in this proceeding, and they believe they may provide a unique insight into the significance of its outcome.

SUMMARY OF ARGUMENT

Petitioners and their amici have argued that RICO "impairs" state insurance laws within the meaning of section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) (1994), because civil RICO "disrupts," "interferes with," "upsets" and "frustrates" state regulation. Receiver Amici, the statutory regulators of insolvent insurers, join Amicus National Association of Insurance Commissioners, the statutory regulators of solvent insurers, to assure the Court to the contrary.

Actual regulatory experiences have proven that civil RICO actions enhance amici's ability to combat fraud by and against insurance companies. Indeed, civil RICO is the most effective tool currently available for collecting looted assets and damages on behalf of insurers that have been victimized by fraud. Access to civil RICO to attack fraud by or against insurers should not be denied. Further, in recent years, amici's anti-fraud efforts have been materially assisted by federal criminal mail and wire fraud prosecutions for conduct that falls within the "business of insurance." The broad finding for preemption sought by Petitioners will compel preemption of the federal criminal mail and wire fraud statutes as applied to such conduct, a result that can only help those criminals who treat insurance companies as their own private piggy banks.

For these reasons, the Receiver Amici urge that affirmance of the decision of the court below is the outcome that will best support effective state insurance regulatory efforts, the public policies that inform those efforts, and the purposes for which Congress ceded regulation of the business of insurance to the states. In addition, the Receiver Amici urge that affirmance of the decision of the court below is compelled by this Court's decision in *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969). There, the Court held that determining whether a general federal statute "impairs" state insurance regulation requires these inquiries: Does the state statute command something that the federal government has prohibited? Conversely, does the federal statute command something that the state insurance laws prohibit? In the case of RICO, the answer to both questions—as applied to every state's body of insurance laws and regulations—is "no." Therefore, RICO is not preempted in Nevada, or elsewhere, by operation of the McCarran-Ferguson Act.

ARGUMENT

I.

THE DIRECT CONFLICT TEST, EMPLOYED IN *SEC v. NATIONAL SECURITIES, INC.*, SHOULD DETERMINE WHETHER STATE INSURANCE LAWS PREEMPT RICO.

Petitioners' argument parrots the two appellate court decisions that hold RICO preempted when the underlying misconduct falls within the scope of the "business of insurance." Receiver Amici, of course, urge that the circuit court decisions holding against preemption have it right; and urge, as these circuits have concluded, that the question of whether a state's insurance law should preempt a federal statute, regardless of whether the federal statute provides materially different remedies, should be determined by the "direct conflict" test employed by the Court in *SEC v. National Securities, Inc.*, 393 U.S. 453.[5]

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[5] Although application of the "direct conflict" test is the jurisprudentially correct methodology for determining whether a federal law "invalidates, impairs or supersedes" a state law regulating the business of insurance under section 2(b) of the McCarran-Ferguson Act, the result of the test in a particular case will inevitably depend on the specific provisions of the federal and state laws at issue. In this case, the Receiver Amici believe that no invalidation, impairment, or supersession exists under either the "direct conflict" test or any other test proposed to this Court. However, they neither believe nor argue here that a "direct conflict" test necessarily mandates a narrow construction of the preemptive effect of the McCarran-Ferguson Act. The result will always depend on the facts of the statutes involved. In this regard the Receiver Amici do not agree with Respondents when they assert that Congress intended that the McCarran-Ferguson Act be narrowly construed.

Petitioners relegate *National Securities* to a footnote, in which it is dismissed as "inapposite." Brief of Petitioners at 19 n.11. But Petitioners are wrong. In that case the SEC asserted the Securities Exchange Act of 1934 as grounds for unwinding a merger between insurers that a state insurance commissioner had approved under the applicable state insurance statute. The Court stated the issue on review: "The question is, then, whether the McCarran-Ferguson Act bars a federal remedy which affects a matter subject to state insurance regulation." 393 U.S at 462.

The Court answered the question by applying the direct conflict test, subsequently reflected in decisions of the First,[6] Third,[7] Fourth,[8] Fifth,[9] Sixth,[10]

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[6] *Villafane-Neriz v. F.D.I.C.*, 75 F.3d 727, 735 (1st Cir. 1996) (Federal Deposit Insurance Act provisions, as applied to an insurance company, are not preempted by the McCarran-Ferguson Act).

[7] *Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185, 190 (3rd Cir.) *petition for cert. filed* (June 23, 1998) (RICO is not preempted by the McCarran-Ferguson Act).

[8] *Mackey v. Nationwide Ins. Companies*, 724 F.2d 419 (4th Cir. 1984) (Neither the prohibition in the Fair Housing Act against redlining nor Title VII's prohibition against employment discrimination is preempted by the McCarran-Ferguson Act).

[9] *Edwards v. Your Credit Inc.*, 148 F.3d 427, 433-34 (5th Cir. 1998) (Truth in Lending Act is not preempted by the McCarran-Ferguson Act in a case involving allegedly improper disclosures about an insurance premium).

[10] *Nationwide Mutual Insurance Co. v. Cisneros*, 52 F.3d 1351 1360-61 (6th Cir. 1995), *cert. denied*, 516 U.S. 1140 (1996) (authority of the Department of Housing and Urban Develop-

(continued...)

Seventh,[11] and Ninth[12] Circuits, all of which support the outcome urged by Respondents and their amici:

> Nevertheless, respondents contend that any attempt to interfere with a merger approved by state insurance officials would "invalidate, impair, or supersede" the state insurance laws made paramount by the McCarran-Ferguson Act. We cannot accept this overly broad restriction on federal power.
>
> It is clear that any "impairment" in this case is a most indirect one. . . . Arizona has not commanded something which the Federal Government seeks to prohibit. It has permitted respondents to consummate the merger; it did not order them to do so. . . . And the remedy the Commission seeks does not affect a matter predominantly of concern to policyholders alone; the merger is at least as important to those owning the companies' stock as it is to those

[10] (...continued)
ment to regulate homeowner's insurance policies under the Fair Housing Act is not preempted by the McCarran-Ferguson Act). *Compare Kenty v. Bank One Columbus, N.A.*, 92 F.3d 384, 391-393 (6th Cir. 1996) (RICO is preempted by state anti-fraud laws that conflict with RICO's remedies and procedural provisions).

[11] *N.A.A.C.P. v. American Family Mut. Ins. Co.*, 978 F.2d 287 (7th Cir. 1992) (Fair Housing Act is not preempted by the McCarran-Ferguson Act in a case charging redlining in insurance sold in connection with the purchase of a dwelling).

[12] *Merchants Home Delivery Serv., Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486 (9th Cir.), *cert. denied*, 516 U.S. 964 (1995); and the decision from which this petition is taken, *Forsyth v. Humana*, 114 F.3d 1467 (9th Cir. 1998) (RICO is not preempted by the McCarran-Ferguson Act).

> holding their policies. In these circumstances, we simply cannot see the conflict.

393 U.S. at 463.

Petitioners contend, nevertheless, that the outcome of *National Securities* turned on the fact that the state and federal statutes in play regulated different conduct and protected different interests. Brief of Petitioners at 19 n.11. But while the Court's observations in this regard, set out in the passage quoted above, supported the outcome, they did not compel it. The outcome was compelled by the crucial inquiry: Did Arizona command something which federal law prohibited? *Id.* Was there, in other words, a direct conflict between a state mandate and a federal prohibition?

In any event, even if the outcome of *National Securities* was driven by the fact that the state and federal statutes regulated different conduct and protected different interests, the same point can be made about state insurance fraud statutes and RICO. The state laws can be broadly described as aimed at fraud by insurance companies. RICO is aimed at conducting or participating in the conduct of an enterprise through—typically and in this case—a pattern of mail and wire fraud proscribed by 18 U.S.C. § 1341 and § 1342. *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 481-83 (1985). Moreover, state insurance fraud laws protect insurance consumers; federal mail and wire fraud laws protect the public in general against criminals' use of the mails to execute schemes to defraud. *See United States v. Sylvanus*, 192 F.2d 96, 100 (7th Cir. 1951) (holding that a criminal mail fraud prosecution based upon the illegal operation of an insurance company is not preempted by the McCarran-Ferguson Act). In other

words, as between state insurance fraud statutes and RICO, they too can correctly be said to aim at different conduct and protect different interests.

Accordingly, Receiver Amici urge that the appropriate question for determining whether RICO falls in the face of state insurance fraud laws must be taken directly from *National Securities*: Do the state laws command something that RICO prohibits? Conversely, does RICO command something that the state laws prohibit? Is there a direct conflict between a state insurance law and a federal statute?[13]

II.

THE BASES FOR PREEMPTION URGED BY PETITIONERS ARE FACTUALLY UNSUPPORTED AND LOGICALLY UNSOUND.

Petitioners do not and cannot dispute that the availability of civil RICO to defrauded insurance consumers *supports* the substantive objectives of relevant Nevada insurance law. *See* Petitioners' Brief at 21. Instead, Petitioners supply a meaningless academic dissertation on the extent to which traditional federal preemption jurisprudence may or may not aid in applying section 2(b) of the McCarran-Ferguson Act to this case.

---

[13] This test comports with the Court's holding in *United States Department of the Treasury v. Fabe*, 508 U.S. 491 (1993). (By operation of the McCarran-Ferguson Act, where there was a direct conflict between a state's priority scheme for distributing the assets of an insolvent insurer and a federal super-priority claim statute, the state scheme preempted the federal statute, insofar as the state scheme regulated the "business of insurance.")

But regardless of labels used in the debate—"reverse preemption," "inverse preemption," "direct conflict," or something else, Petitioners still need to establish the proposition that the availability of civil RICO to Respondents serves to "invalidate, impair or supersede any law enacted by [Nevada] for the purpose of regulating the business of insurance." Petitioners offer nothing more than speculation about legislative intent and the effect of civil RICO in support of their conclusions. Receiver Amici submit that this Court should not decide a case of this magnitude, involving as it does, important legislative policy determinations by two sovereigns, merely on the basis of speculation and assumptions.

Petitioners' remaining section 2(b) arguments involve the procedural and remedial provisions of Nevada's insurance laws and assumptions about the effects of civil RICO. Petitioners conclude that either because of differences between civil RICO and specific procedural and remedial aspects of Nevada law, or because Nevada has somehow exclusively occupied much or all of the "field" involving insurance consumer protection, RICO runs afoul of section 2(b) of the McCarran-Ferguson Act.[14]

But the bases for Petitioners' arguments about some kind of irreconcilable clash between civil RICO and the procedural and remedial components of the Nevada

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[14] Petitioners do not explicitly argue for a "field preemption" test, for the plain reason that elsewhere they argue the inapplicability of such field preemption reasoning in section 2(b) cases. Petitioners' Brief at 14. Nonetheless, the argument beginning at page 20 of Petitioners' Brief is essentially a "field preemption" argument without the label.

insurance laws are, at most, debatable, and in general no more compelling than a variety of alternative speculations and assumptions. For example, while Petitioners concede that a private right of action exists in Nevada for unfair insurance trade practices, Petitioners' Brief at 7, they argue that the availability of treble damages and attorneys' fees in a civil RICO case, nowhere mentioned in the Nevada unfair trade practices law, presents such a disparity in remedies that the Nevada laws would be impaired or superseded by RICO. Petitioners' Brief at 21-2. However, besides freighting more than seems plausible on what the Nevada legislature did *not* say, Petitioners ignore the obvious point that an unfair insurance trade practice claim is not the same thing as a RICO claim that may involve, *inter alia*, unfair insurance trade practices. Whatever may be concluded from what the Nevada legislature did not say about damages recoverable in a simple case of unfair trade practices, it seems sheer conjecture that Nevada intended its laws to serve as a shield to those who engage in the types of patterns and practices of criminal misconduct that RICO was intended to address.[15]

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[15] Petitioners broadly argue that RICO has no applicability to the business of insurance, but ignore the fact that actions taken within the business of insurance can have drastic financial and other consequences for those outside the insurer-policyholder "core" focus of the business of insurance identified by this Court in *National Securities*. Even if the Nevada legislature somehow intended to deprive consumers of RICO remedies, one could hardly argue that the legislature meant the Nevada insurance laws to have the same effect on general creditors, reinsurers, guaranty associations, employees, and others.

Similarly, Petitioners note the seeming inconsistency between the administrative nature of procedures for violations of Nevada insurance law, and the redress of such violations through the type of private right of action involved in a civil RICO case. Petitioners' Brief at 7. But the fact that the administration of that State's insurance laws is largely effected through an administrative agency is no more indicative of the existence and scope of private rights of action than is the case under the federal securities laws. *Cf. National Securities*, 393 U.S. at 467.

Finally, this Court should note the role of state insurance commissioners in enforcing state insurance laws, and their familiarity with the such laws and their procedural and remedial components. *See N.A.A.C.P. v. American Family*, 978 F.2d at 297. Amicus National Association of Insurance Commissioners, like the Receiver Amici, submits that civil RICO cases can and do enhance the effective administration of state insurance laws.

III.

PREEMPTING RICO WHERE THE MISCONDUCT INVOLVES THE BUSINESS OF INSURANCE WILL PROTECT CRIMINALS AND UNDERMINE INSURANCE REGULATORS' EFFORTS TO PREVENT FRAUD BY AND AGAINST INSURANCE COMPANIES.

Petitioners and their amici are, of course, all insurance companies or trade organizations for insurance companies—the intended targets of state regulation. Ironically, they nevertheless advance the pious asser-

tions that frauds committed by insurance companies be exempt from RICO lest state regulation be "disrupted," "interfered with," "upset," and/or "frustrated" (all of which terms sound perilously close to "conflict"). Brief of Amici Alliance of American Insurers, *et al.* at 27-29. Amicus Consumer Credit Insurance Association goes so far as to assert at page 16 of its brief that not exempting their members' misconduct from RICO "overturns this [state regulatory] system." All of these are mere naked contentions; for neither the Petitioners nor their amici offer a single concrete example from real life of RICO's actually interfering with state insurance regulation.[16]

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[16] Amici Alliance of American Insurers, *et al.* point to the successful administrative remediation of massive fraud claims against Prudential Insurance Company, Brief of Amici at 20, as an illustration of the contention that defrauded policyholders do not need RICO to obtain redress. But it is just as possible that Prudential settled those claims to *avoid* a policyholders' RICO suit. In other words, if this remediation illustrates anything relevant, it is that the availability of civil RICO does not prevent administrative remediation of significant disputes.

Amicus Consumer Credit Insurance Association argues that if policyholders can pursue civil RICO actions based upon alleged fraud involving policy forms and rates, insurers will be deterred from settling disputes about forms and rates with state regulators. Amicus Brief at 15-17. This stands logic on its head. If policyholders can pursue civil RICO actions, insurers should be deterred from committing fraud in connection with policy forms and rates in the first place!

A. Regulators of Solvent Insurance Companies Believe RICO Enhances Their Ability to Combat Fraud By and Against Insurance Companies.

The Receiver Amici respectfully encourage the Court to seek counsel about effective insurance regulation from the state insurance regulators, not from the companies whose conduct is the target of the regulation. These regulators have appeared as amici, through the National Association of Insurance Commissioners, to advise that RICO enhances their regulatory efforts. It does not disrupt, interfere, upset or frustrate them. For these reasons, these regulators have urged that RICO not be held preempted by the McCarran-Ferguson Act.

B. Regulators of Insolvent Insurance Companies Have Found RICO to be a Significant and Effective Tool for Recovering the Assets of Defrauded Insurers.

Likewise, the Receiver Amici, "regulators" of insolvent insurers, respectfully advise that RICO enhances their ability to do their job of marshalling the assets of insolvent insurers, particularly where they are called upon to recover looted assets and consequential damages resulting from the illegal operation of the insurer before it failed. State statutory and common law actions are just not as effective as RICO. State service of process and subpoena powers do not reach as far as RICO's nationwide service of process—an important consideration in frauds against large insurers, which are typically perpetrated by out-of-state actors. (For example, individual defendants and several non-defendant key witnesses in Amicus Hittner's RICO suit, filed in Rhode Island where the defrauded insurers were

domiciled, reside in New York, California, and Texas.) State actions are often complicated by quirky state contribution-among-tortfeasor or non-party-at-fault rules, which are inapplicable in RICO cases. *E.g.*, *First American Corp. v. Al-Nahyan*, 948 F. Supp. 1107, 1118 (D.D.C. 1996) (contribution and indemnification unavailable under RICO); *Friedman v. Hartmann*, 787 F. Supp. 411, 417-18 (S.D.N.Y. 1992) (same). State actions are subject to local statutes of limitations, which often provide extra measures of protection to fraudfeasors that are unavailable in a RICO action. *E.g.*, 735 Ill. Comp. Stat. 5/13-214.2 (West 1998) (providing two-year limitations period for actions against accountants).

The Receiver Amici recognize that there is a distinction between the alignment of the parties in the case on review on the one hand, and in suits the Receiver Amici have filed on the other. In the case on review, an insurance company is alleged to have defrauded policyholders. In the Receiver Amici's cases insurance companies are alleged to have been the victims of fraud committed by their owners and operators and by third parties. But both fact constellations involve conduct that falls squarely within the "business of insurance."[17]

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[17] *Hittner v. Sequa* involves alleged misconduct in connection with obtaining regulatory approval for the sale of insurance companies. The Court has recognized that regulatory approval of such sales "clearly relates to the 'business of insurance.'" *National Securities*, 393 U.S. at 462. In *Schacht v. Brown* and *Clark v. Milam* the underlying misconduct involved alleged misstatements on financial statements required by and filed with state and federal regulators. Statutes and regulations aimed at monitoring the solvency of insurers, such as require-

(continued...)

If the Court reverses the decision on review, RICO may well be preempted in all suits filed for victimized insurance companies. In other words, the question on which the Court granted certiorari, stated in its short form, is this:

> Whether the application of RICO to the business of insurance would "invalidate, impair or supersede" state law regulating the same conduct in contravention of the McCarran-Ferguson Act?

If the Court answers that question with an unqualified "yes," it is likely that no civil RICO action involving the business of insurance could ever be pursued, whether the underlying misconduct was committed by or against an insurance company.

C. If Civil RICO Is Preempted Where the Underlying Misconduct Involves the Business of Insurance, Federal Criminal Mail Fraud and RICO Prosecutions of the Same Misconduct May Be Preempted As Well.

If the Court answers the certiorari question in the affirmative, criminal mail and wire fraud prosecutions under 18 U.S.C. § 1341 and § 1342 for frauds by and against insurance companies will also, apparently, be subject to McCarran-Ferguson Act preemption. The logic seems inescapable. Under Petitioners' theory, any federal statute that directly or indirectly regulates or

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[17] (...continued)
ments that insurers follow prescribed rules when accounting for financial results and report on those results to the insurance commissioners, are "core" regulation of the business of insurance under *National Securities*, 393 U.S. at 460.

penalizes conduct that is the "business of insurance" interferes with state insurance regulatory schemes that regulate or penalize the same conduct and, accordingly, is preempted.

Every state prohibits fraud committed by or against insurance companies. Every state also has legislatively prescribed criminal penalties for such frauds.[18] There is no principled basis for holding that a federal statute that provides civil remedies for misconduct by or against an insurance company is preempted because state statutes also provide such remedies, whereas a federal statute that provides criminal penalties for such misconduct is not preempted, even though state statutes also provide such penalties.

The Eighth Circuit attempted a distinction. In 1997 that court held the McCarran-Ferguson Act preempted a civil RICO action filed against an insurer by a bank borrower for whom the bank bought insurance as a condition of making the loan. *Doe v. Norwest Bank Minnesota, N.A.*, 107 F.3d 1297 (8th Cir. 1997). Months later the court reviewed the mail fraud convictions of individuals who had given the Missouri insurance commissioner false financial information about Missouri insurance companies they controlled. *United States v. Blumeyer*, 114 F.3d 758 (8th Cir.), *cert. denied*, 118 S.Ct. 586 (1997).[19] The defendants argued that *Doe v. Norwest Bank* compelled preemption.

[18] Relevant statutes in the Receiver Amici's home states include 215 Ill. Comp. Stat. 5/134 (providing that falsification of records for purposes of defrauding insurance company, or any other company or person, is Class 4 Felony); R.I. Gen. Laws § 27-94-1 (providing fine of up to $50,000 and sentence of up to 20 years imprisonment, or both, for frauds with respect to financial condition of insurance company) and R.I. Gen. Laws § 27-47-1 *et seq.* (1998) (providing criminal sanctions for the failure to report impairment in insurance company's financial condition); W.Va. Code § 33-4-8 (1998) (providing general penalty of fine of up to $1,000 and sentence of up to six months imprisonment for person convicted of misdemeanor for violation of insurance code) and W.Va. Code § 33-35-1 *et seq.* (providing criminal sanctions for failure to report impairment in insurance company's financial condition).

The court disagreed, giving this as a reason: a civil RICO claim based on mail fraud could wreak "potential havoc" on state regulation whereas a criminal prosecution for mail fraud had no such potential. *Blumeyer*, 114 F.3d at 768. But this is no reason; it is, at most, guesswork unsupported by a single fact. The court also held that criminal mail fraud should survive McCarran-Ferguson Act preemption, but civil RICO based on criminal mail fraud should not: "And our particular concern in *Doe*—that wronged policyholders would turn to RICO suits instead of pursuing administrative channels of relief—is simply inapplicable here, for private parties are not empowered to bring criminal fraud charges." *Id.* (internal citation omitted). This is more unsupported guesswork. There is no evidence that wronged policyholders' RICO suits interfere with administrative processes. If they did, state legislators could stop the interference by merely prohibiting such suits. *Cf. N.A.A.C.P. v. American Family Mut. Ins. Co.*,

[19] In a statute has been on Missouri's books since the 1920's, Missouri provides that giving false information to the insurance commissioner is a crime punishable by a fine not exceeding one thousand dollars and by imprisonment for not less than two months in the county or city jail, nor more than five years in the penitentiary. Mo. Rev. Stat. § 374.210(3) (1998).

978 F.2d at 297; and *see* Brief of Amicus Curiae National Association of Insurance Commissioners.

Moreover, the reasoning ignores the fact that the holding effectively prohibits more than just policyholders' civil RICO suits. As pointed out above, it also effectively prohibits civil RICO suits brought on behalf of insurance companies that have been looted or otherwise defrauded. Finally, the reasoning disregards the structure of the RICO statute. RICO contains a single prohibitory section, 18 U.S.C. § 1962, which describes standards enforced through the criminal penalties provided in § 1963 and the civil remedies provided in § 1964. There is not one type of RICO violation that is a basis for § 1963 criminal consequences and another that is a basis for § 1964 civil consequences. If § 1962 is violated—say by the operation of an insurance company through a pattern of mail fraud—either may be invoked. Under the Eighth Circuit's reasoning, however, a criminal RICO prosecution for such a violation could proceed, but a civil RICO action for damages would be preempted. Such an anomalous result must be and is wrong. Either both mail fraud crimes and civil RICO actions by or against insurers based on predicate acts of mail fraud are preempted by the McCarran-Ferguson Act, or neither are preempted.

D. The Business of Insurance Attracts Criminals. Every State and Federal, Civil and Criminal Tool for Fighting Fraud By and Against Insurance Companies Should Be Preserved.

The United States Congress has recognized that the business of insurance is a magnet for criminals. As the House Committee on Energy and Commerce explained

in a report issued after its extended study of insurance insolvencies:

> The business of insurance is uniquely suited to abuse by mismanagement and fraud. Making believable promises is a stock item in every con man's bag of tricks. The prepayment of large, often vast, sums of money with few restrictions lends itself naturally to monumental wasting of assets through greed, incompetence, and dereliction of duty. This combination of easy money based on easy promises makes the insurance industry an irresistible target for financial knaves and buccaneers.

Staff of House Committee on Energy and Commerce, 101st Cong. 2d Sess., Failed Promises: Insurance Company Insolvencies (Comm. Print 101-P 1990).

Crimes against insurance companies invariably are committed by conducting "the business of insurance" in an illegal manner.[20] The Receiver Amici urge that every

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[20] Here are the facts from some contemporary reported opinions:

1. Charles Christopher and Wayne Reeder wanted to buy two insurance companies. They represented to the regulators that if the regulators approved the purchases, they would strengthen the financial condition of the companies by contributing valuable real estate, owned by Reeder, to the companies. They promised the regulators that by the time the purchases were approved all existing liens on the property would be paid in full. But Christopher and Reeder broke their promise. When the regulators approved the purchases, the liens had not been paid—a fact that was hidden from the regulators. Within weeks of obtaining control of the insurance companies, Christopher and Reeder diverted approximately $40 million of insurance company money to their own ac-

(continued...)

available tool for combatting crimes by or against insurance companies should be preserved. For the reasons given, under this Court's precedent a holding that the McCarran-Ferguson Act does not preempt civil RICO will be right, both as a matter of law and as a matter of sound public policy.

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[20] (...continued)

counts, using the funds to clear the liens and pay off other personal and business debts. Both companies failed, of course, unable to recover from the looting. Christopher and Reeder were both convicted of mail fraud. *United States v. Christopher*, 142 F.3d 46 and *United States v. Reeder*, No. CR 93-41(02)B (D.R.I. June 27, 1997).

2. Lawrence Neadle gave false financial information to regulators in order to obtain approval to operate a property and casualty insurer in the Virgin Islands. The misconduct was discovered after the insurer's policyholders suffered more than $37 million of losses in a hurricane, none of which the insurer could pay. Neadle pleaded guilty to mail fraud. *United States v. Neadle*, 72 F.3d 1104 (3rd Cir. 1995).

3. Glenn Martin operated a life insurance company. He looted $9,750,000 from the company by concealing policy sales and premiums from the insurance regulators, who were closely monitoring his activities because of their concern about the insurer's solvency. Martin and his sister, who was the corporate secretary, were convicted of conspiracy and mail fraud. *United States v. Cooper*, 132 F.3d 1400 (11th Cir. 1998).

Other published opinions describing contemporary prosecutions for mail fraud that victimized insurance companies include: *United States v. Sokolow*, 91 F.3d 396 (3rd Cir. 1996), *cert. denied*, 117 S.Ct. 960 (1997); *United States v. Cavin*, 39 F.3d 1299 (5th Cir. 1994); *United States v. Cosentino*, 869 F.2d 301 (7th Cir. 1989); *United States v. Bailey*, 859 F.2d 1265 (7th Cir. 1988); *United States v. Sylvanus*, 192 F.2d 96; *United States v. Stewart*, No. 96-583, Mealey's Litigation Reports: Insurance Insolvency, H-1 (E.D. Pa. August 3, 1998) (copies of this decision have been lodged with the Court).

CONCLUSION

For all these reasons the Receiver Amici respectfully urge that the Court affirm the decision of the court below.

Respectfully submitted,

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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1997

HUMANA INC. AND
HUMANA HEALTH INSURANCE OF NEVADA, INC.,
Petitioners,

v.

MARY FORSYTH, MARIETTA CADE, WILLIE ANDREWS,
MARY LOU BUEHLER, HELEN STAVES,
RANDOLPH BRATTON, AND SEARLE AUTO GLASS, INC.
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF ON THE MERITS OF AMICUS CURIAE UNITED POLICYHOLDERS IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

The question presented is whether the application of the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. 1961, *et seq.*, to insurance companies would "invalidate, impair or supersede" state statutory[1] insurance law in violation of the McCarran-Ferguson Act.

---

1. The McCarran-Ferguson Act protects laws "enacted" by the States. *See* 15 U.S.C. § 1012(b). Only statutory law, not the common law or insurance department regulatory law, is "enacted" within the ordinary meaning of that word.

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STATEMENT OF STANDING

United Policyholders, as *amicus curiae*, has obtained the consent of both the Petitioners and the Respondents to submit this brief. The letters of consent have been lodged with the Clerk of the Court.

INTEREST OF THE AMICUS CURIAE

United Policyholders is a national, not-for-profit educational organization whose mission is to educate the public, legislators and the courts on insurance issues and consumer rights, and to assist policyholders in securing prompt and fair insurance settlements.[2] The resolution of the issue presented in this case is of great importance to United Policyholders and its members. The RICO statute is an important tool used by policyholders nationwide to combat patterns of fraud in the insurance industry.

SUMMARY OF ARGUMENT

Rather than focus on what test this Court should apply to determine whether RICO impairs state insurance statutes, in particular Nev. Rev. Stat. § 686A.310.2, United Policyholders' Brief addresses whether RICO actually impairs state insurance laws.

Petitioners argue that RICO's remedies are more draconian than those allowed under state law and, for that reason, disrupt a comprehensive state system designed to remedy insurance company fraud. *See* Brief on the Merits of Petitioners at 21-25. Similarly, *amici curiae*, Alliance of American Insurers ("AAI"), American Council of Life Insurance ("ACLI"), Blue Cross and Blue Shield Association ("BCBSA"), Health Insurance Associations of America ("HIAA"), National Association of Independent Insurance ("NAII"), National Association of Mutual Insurance Companies ("NAMI"), and Reinsurance Association of America ("RAA") (collectively, the "Insurance Industry *Amici*") point

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2. No counsel for any party in this case authored this brief in whole or in part, and no person or entity other than United Policyholders and its members made any monetary contribution to the preparation or submission of this brief.

to the "draconian" and inflexible nature of RICO's mandatory treble damage provision. *See* Brief of AAI, ACLI, BCBSA, HIAA, NAII, NAMI and RAA as *Amicus Curiae* in Support of Petitioners at 22-29 ("Insurance Industry *Amici* Brief").

Petitioners and the Insurance Industry *Amici* demonstrate a misunderstanding of the allegedly comprehensive state regulatory schemes upon which they rely. Like most states, Nevada has adopted a version of the Unfair Trade Practices Model Act developed by the National Association of Insurance Commissioners. All state insurance regulatory schemes based on the Unfair Trade Practices Model Act leave intact private remedies under common law or other, non-insurance, statutory law for insurance company unfair trade practices and fraud. These schemes expressly leave intact other state and federal criminal law, like RICO. Indeed, imperiled by this case is the application to insurance companies of every federal criminal statute enacted over the last fifty years.

The insurance industry historically asserted the existence of these other remedies to avoid an expansion of the remedies that insurance commissioners could impose. The insurance industry utilizes the full range of private remedies, including RICO, to address policyholder fraud.

Insurance industry fraud can be national in scope and affect millions of policyholders.[3] Because the state insurance regulatory system was never designed to be the only weapon in the fight against insurance company fraud, the use of RICO is fully consistent with, and does not impair, state unfair trade practices acts.

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3. For instance, the New Jersey Supreme Court held that the insurance industry misled the nation's insurance regulators in securing approval of a standard exclusion contained in standard-form Comprehensive General Liability insurance policies sold to millions of policyholders. *See, Morton Int'l, Inc. v. General Accident Ins. Co.*, 629 A.2d 831, 848-55 (N.J. 1993), *cert. denied sub nom., Ins. Co. of N.Am. v. Morton Int'l, Inc.*, 512 U.S. 1245 (1994). The Court refused to give effect to the industry's judicial interpretation of the exclusion because to do so would require "ignoring the industry's misleading presentation to regulators over twenty years ago, and overlooking the apparent unfairness that such an interpretation would impose on policyholders who were charged rates that did not reflect the radical diminution in coverage contemplated by the insurance industry." *Id.* at 873.

LEGAL ARGUMENT

I. THE REMEDIES IN STATE UNFAIR TRADE PRACTICES ACTS ARE NOT EXCLUSIVE VEHICLES FOR AFFORDING PRIVATE REMEDIES TO POLICYHOLDERS HARMED BY INSURANCE COMPANY FRAUD

The state unfair insurance trade practices acts dealing with insurance fraud, including the Nevada Act at issue herein, are usually derived from the Unfair Trade Practices Model Act (the "Model Act") developed by the National Association of Insurance Commissioners ("NAIC"). *See* Brief of *Amici Curiae* National Association of Insurance Commissioners Supporting Respondent, *Prometheus Funding Corp. v. Merchants Home Delivery Services, Inc.*, No. 95-409 (U.S. filed Sept. 29, 1995) at 2; *Tweet v. Webster*, 614 F. Supp. 1190 (D. Nev. 1985).

A review of the NAIC's adoption of the Model Act reveals that: (1) it was never intended to provide an exclusive vehicle for awarding private remedies for insurance company fraud; (2) at the insurance industry's request, the NAIC rejected a proposal to allow insurance commissioners to order private restitution because the insurance industry insisted that policyholders already had other common law and statutory remedies; (3) the Model Act did not incorporate anti-discrimination provisions because policyholders had remedies under existing non-insurance civil rights laws; and, (4) the Model Act specifically provided that its remedies for insurance company fraud did not replace private remedies available under non-insurance statutes and the common law.

From 1947 to the early 1970's, the Model Act regulated misrepresentation and false advertising of policy contents; false information and advertising with respect to the business of insurance; defamation; boycott, coercion and intimidation; false financial statements, stock operations and advisory board contracts; unfair discrimination in the making of life insurance or accident or health insurance rates; and rebates for life insurance, life annuity, or accident and health insurance policies. *See All-Industry Committee Draft, (January 24, 1947), (final draft) of an Act Relating to Unfair Competition and Unfair and*

Deceptive Acts and Practices in the Business of Insurance, 1960-2 NAIC Proc. 486, 500-510.[4]

In the early 1970s, the NAIC considered fundamental revisions to the Model Act and appointed an insurance Industry Advisory Committee to review the proposed changes. *See, generally*, 1971-2 NAIC Proceedings 341. Many of the Insurance Industry *Amici* appearing in this case were members of the Industry Advisory Committee.

A. The Insurance Industry, Including Many of the Insurance Industry *Amici*, Strenuously Opposed State Insurance Department Involvement In Awarding Private Remedies for Insurance Company Unfair Trade Practices, Including Fraud

One proposed revision to the Model Act considered by the NAIC would have allowed insurance commissioners to award private damages for insurance company unfair trade practices, including fraud. The proposed Section 8(a)(C) provided as follows:

> [T]he (Commissioner) may, at his discretion, order any one or more of the following:
>
> C. Such other relief as is reasonable and appropriate.

See Report of the Industry Advisory Committee to the NAIC B-6 Subcommittee to Review the Model Unfair Trade Practices Act, Nov. 29, 1979, 1972-1 NAIC Proceedings 490, 498.

The Industry Advisory Committee "object[ed] strenuously" to the proposed extension of the commissioners' authority. The Industry Advisory Committee expressed its concern that Section 8(a)(C) "tends to confer the powers of an equity court upon the Commissioner but without the limitations or safeguards that are proscribed for traditional proceedings." It opined that "we do not believe a Commissioner should attempt to fill a role that is usually the province of a jury — that is, ascertain who may have been harmed and to what extent." *Id.* at 510.

4. The NAIC proceedings referenced herein can be found in the "NAIC" file of the "INSURE" library on the LEXIS system.

The insurance industry explained that policyholders already could use other remedies at law to combat unfair trade practices, like insurance company fraud, and that to allow the commissioner to also award such damages would sanction a double recovery. This view was expressed by Robert S. Sieler, Chairman of the Industry Advisory Committee, in his testimony accompanying the Committee's submission of its report to the NAIC:

> In the more serious cases, the public has the very real and effective capability of using remedies at law that now exist. This clause makes prosecutor, judge and jury out of the Commissioner and still would subject the insurer and agent to the public's statutory and common law remedies.

Statement by Robert S. Sieler, Chairman, Industry Advisory Committee, Unfair Trade Practices (B-6), Subcommittee to the NAIC Laws, Legislation and Regulation (B) Committee, 1972-1 NAIC Proceedings 443, 446 (emphasis added).

The Industry Advisory Committee warned the NAIC that it was "very seriously concerned about this matter" and that it could not "endorse the Act with this provision in it." *Id.* Chairman Sieler's remarks were echoed by key insurance industry organizations, including the American Life Convention ("ALC"), the Life Insurance Association of America ("LIAA"), the HIAA, and the National Association of Life Underwriters ("NALU"). These insurance industry representatives complained that "Section 8(a)(C) . . . is an unlimited grant to the Commissioners, administrative officials, of the authority or power usually reserved to courts of equity." Statement by the ALC, LIAA, HIAA, and NALU to the NIC (B), Committee, re: Revised Unfair Trade Practices Act, 1972-1, NAIC Proceedings 443, 447.

Two of the Insurance Industry *Amici*, AAI (known at the time as the American Mutual Insurance Alliance) and NAII, strongly argued against the adoption of Section 8(a)(C) because the authority to award "other relief" was "so all-encompassing as to grant the regulator the power to impose judicial type remedies without the protection of appropriate judicial procedures." Statement to the NAIC (B) Committee

by Mr. Donald McHaugh on behalf of the NAII, AMIA, & State Farm Mutual Insurance Company, 1972-1 NAIC Proceedings 443, 448.

The Industry Advisory Committee and the involved Insurance Industry *Amici* achieved their objective. The insurance commissioners' power to order restitution to policyholders embodied in Section 8(a)(C) was deleted from the Model Act by the Law, Legislation & Regulation (B) Committee. 1972-1 NAIC Proceedings at 490. Thus, due to the insurance industry's strong opposition, the Model Act and the numerous state laws subsequently patterned after it have largely left the award of private damages for insurance company unfair trade practices and fraud to other non-insurance statutory law and common law.

Having successfully convinced the NAIC not to exclusively occupy the area of private remedies for insurance company fraud, it is exceedingly strange that the Insurance Industry *Amici* would represent to this Court that the state insurance codes, particularly the various state unfair insurance trade practices acts, comprehensively regulate the area of private remedies to the exclusion of private rights under other non-insurance statutes or the common law.

B. The Language Of The Model Act Explicitly Preserved The Application Of Other Law To Regulated Activity

Section 9(d) of the Model Act indicates clearly the NAIC's intent that the Model Act would coexist with other non-insurance laws that provide private remedies for insurance company fraud. In arguing that Section 8(a)(C) should not be adopted, the Insurance Advisory Committee stressed that persons injured by unfair trade practices "have an adequate remedy at law." 1972-1 NAIC Proceedings at 509. In advancing this argument, the Industry Advisory Committee specifically pointed to Section 9(d) of the Model Act as "mak-[ing] this very clear." *Id.*

Section 9(d) provides, in its entirety, that:

> (d) No order of the (Commissioner) under this Act or order of a court to enforce the same shall relieve or absolve any person affected by such Order from any liability under any other laws of the State.

Id. at 509.

This language, or substantially similar language, appears in virtually every state insurance code section that deals with insurance unfair trade practices.[5] The language in the Model Acts and the various state codes makes it absolutely clear that the Model Act was not designed to impair other remedies for insurance company unfair trade practices.[6]

C. Due To The Opposition Of The Insurance Industry, The NAIC Rejected A Proposal To Add A Class Action Remedy And A Non-Discrimination Provision To The Model Act

The NAIC considered another provision that would have given state insurance commissioners the power to bring class actions on behalf of consumers for violations of the Model Act. The Industry Advisory Committee strongly recommended against the inclusion of "any provision for consumer class action suits for damages resulting from violation of the Act. . . ." First Report of the Advisory Committee to the NAIC B-5 Subcommittee to Review the Model Unfair Trade Practices Act, June 16, 1971, 1971-2 NAIC Proceedings 341, 350.

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5. *See* Ariz. Rev. Stat. § 20-456.C (1997); Ark. Code Ann. § 23-66-212(d) (1997); Cal. [Ins.] Code § 790.09 (Deering 1997); Conn. Gen. Stat. § 38a-817(d) (1997); Del. Code Ann. tit. 18, § 2308(g) (1997); Del. Code Ann. tit. 18, § 2309(e) (1997); Haw. Rev. Stat. § 431:13-202(b) (1997); Idaho Code § 41-1319(8) (1997); 215 Ill. Comp. Stat. 5/428 (3) (1998); Ind. Code Ann. § 27-4-1-10 (1998); Iowa Code § 507B.8 (1997); Ky. Rev. Stat. Ann. § 304, 12-120(4) (Michie 1996); Mich. Comp. Laws § 500.2049 (1997); Minn. Stat. § 72A.29 (1997); Mich. Stat. Ann. § 24.12049 (1997); Minn. Stat. § 72A.29 Subd. 1 (1997); Miss. Code Ann. § 83-5-43(4) (1997); Mont. Code Ann. § 33-18-1004(4) (1997); Neb. Rev. Stat. § 44-1530 (1997); N.J. Stat. Ann. § 17B:30-17 (1998); N.J. Stat. Ann. § 17:29B-8 (1998); N.M. Stat. Ann. § 59A-16-27.E (1998); N.C. Gen. Stat. § 58-63-35(d) (1997); N.Y. Ins. Law § 2409(b) (Consol. 1997); Okla. Stat. tit. 36, § 1208.D. (1997); Or. Rev. Stat. § 731.252(2) (1997); R.I. Gen. Laws § 27-29-7(d) (1997); Tenn. Code Ann. § 56-8-110(d) (1997); W. Va. Code § 33-11-6(c) (1998); and Wyo. Stat. Ann. § 26-13-115(d) (1997).

6. The relevant savings language appears both in unfair trade practices statutes that have been held to provide for a private right of action and in statutes that have been held not to provide any private right of action.

Among other things, the Industry Advisory Committee told the NAIC that "[t]he common law in all states recognizes the principal of representative actions, so the consumer is not without remedy in this area. . . ." *Id.* The insurance industry argued that reform was unnecessary because the problem was already addressed under relevant non-insurance law. Again, the insurance industry prevailed and the NAIC did not address this area.

The NAIC also considered adding a non-discrimination provision to the Model Act which would affect the "underwriting practices of insurers." The non-discrimination provision "would have restricted the right of insurers to reject persons as risks solely because of race, color, creed, marital status, sex, national origin, residence, age, lawful occupation, failure to place collateral insurance, or previous refusal by another insurer." Remarks of Co-Chairman Durkin, Laws, Legislation & Regulation (B) Committee; Unfair Trade Practices (b)6) Subcommittee, 1972-1 NAIC Proceedings 490, 491.

Among other reasons, the NAIC "decided not to incorporate such provisions because: (1) Some of these matters are presently covered in civil rights laws. . . ." Once again, the NAIC rejected an expansion of the Model Act's protection for policyholders because the insurance industry argued successfully that other remedies were sufficient to protect policyholders. Even though insurance underwriting is an area of intense state insurance regulation, the NAIC clearly intended that federal laws of general application could and would apply to insurance companies, without any resulting impairment of the Model Act or state statutes.

At every turn in the course of the NAIC proceedings, the insurance industry, including several of the Insurance Industry *Amici*, argued that comprehensive administrative remedies for insurance company fraud were unnecessary because private remedies were available under non-insurance statutory and common law. The text of the Model Act, which explicitly preserves policyholders' other remedies, supported these arguments.

Plainly, the Model Act and the state insurance codes are not designed to provide a comprehensive and balanced administrative system providing exclusive remedies for defrauded policyholders. Policyholders are free to utilize non-insurance statutory and common law, including federal law (*e.g.*, the federal civil rights statutes). Accordingly, RICO does not "invalidate, supersede, or impair" state insurance unfair trade practices statutes.[7]

II. THE STATE REGULATORY STRUCTURE DOES NOT EXCLUSIVELY HANDLE THE TASK OF REMEDYING EACH INDIVIDUAL POLICYHOLDER'S DAMAGES CAUSED BY INSURANCE COMPANY FRAUD

As the foregoing reveals, state insurance codes do not authorize insurance departments to award damages to individuals harmed by insurance company unfair trade practices and fraud. State insurance departments often have difficulty addressing even widespread patterns of insurance company fraud, let alone each individual policyholder's complaint of fraud.

In 1996, the Colorado Insurance Department received over 7,000 consumer complaints against insurance companies. The Insurance Department imposed fines in only seven of these cases, one-tenth of one percent. The highest penalty imposed was $20,000.00. Scott J. Paltrow, *Insurance-Industry Lawyer Hired to Audit its Watchdog*, Wall St. J., June 11, 1998, at B2. In response to complaints, the Insurance Division hired a law firm to audit its enforcement activities. The law firm, Sonnenschein Nath & Rosenthal, represented many insurance companies against which complaints had been filed, including: Prudential Insurance Company of America, which

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7. Like the Model Act, RICO was not intended to displace remedies under other laws:

> Nothing in this title shall supersede any provision of Federal, State, or other law imposing criminal penalties or affording civil remedies in addition to those provided for in this title.

Pub. L. No. 91-452, § 904(b), 84 Stat. 941, 947 (1970). *See also, Neibel v. Trans World Assurance Co.*, 108 F.3d 1123, 1130-31 (9th Cir. 1997) ("plaintiff may receive both treble damages under RICO and state law punitive damages for the same course of conduct").

had 33 consumer complaints filed against it, the highest of any life insurance company; Allstate Insurance Company, which had 375 complaints, the third highest for an automobile insurance company; Travelers Group; Aetna; New York Life; and three of the insurance industry's largest trade groups. *See id.*

In New York State, when a policyholder files a complaint in which there are disputed underlying facts, the Insurance Department "generally close[s] these complaints as 'Questions of Fact' and [the Insurance Department] do[es] not count them against an insurer." *See* New York State Insurance Department, *1995 Annual Ranking of Automobile Insurance Companies*, at 4.

The Indiana Insurance Department regulates 1,800 insurance companies with a budget of only slightly over $4 million annually. Sally McCarthy, the Indiana Insurance Commissioner, candidly admits that the Department has been unable to take action even against insurance companies "that repeatedly refuse to pay claims and that mislead customers." Scott J. Paltrow, *A Matter of Policy; How a State Becomes Popular with Insurers — But Not Consumers*, Wall St. J., Jan. 14, 1998, at 1.

Since 1993, the Indiana Insurance Department has received a total of 21,000 complaints. Over the same period, the Department has sent 211 warning letters to 72 companies. Disciplinary action has been taken against eleven companies. In only one of these cases was the action taken in response to consumer complaints. *Id.* The Insurance Department's legal division "almost never takes action," even when the Insurance Department's consumer services division refers files concerning insurance companies it believes to be violating the state's Unfair Claims Practices law. *Id.*

Illustrative of the problem is the experience of fifty policyholders who filed complaints with the Indiana Insurance Department alleging that State Farm Insurance Company was low-balling their claims resulting from a chain of severe thunderstorms which damaged hundreds of thousands of homes on April 19, 1996. "In nearly identical complaints," these policyholders complained that State Farm offered to pay their claims at far less than the actual cost of repairs and "withheld

payments until consumers agreed to settle." *Id.* The Insurance Department sent State Farm fourteen notices that the Insurance Department "believe[s] that your company may have committed violations of the Unfair Claims Settlement Practices Statute." *Id.* The consumer services division asked the legal department to investigate but the legal department has not been able to do much. *Id.* When the legal department receives large numbers of consumer complaints about specific insurance companies, these complaints are referred to outside law firms for evaluation. Since 1991, none of these outside law firms, "often politically well-connected, and some [of which] derive their income from representing insurance companies as well, [has] produced an evaluation that has resulted in disciplinary action against an insurance company." *Id.*

According to the same Wall Street Journal article, state insurance regulators all across the country have "failed to detect widespread sales fraud by several of the nation's biggest life-insurance companies, *despite thousands of consumer complaints*." *Id.* (emphasis supplied).

State regulators took disciplinary action only after policyholders filed lawsuits and the press reported the abuses. *Id.* While the Wall Street Journal recognizes this as a failure of the state insurance regulatory system, the Insurance Industry *Amici* herald this series of events as an unqualified success. *See* Insurance Industry *Amici* Brief at 20-21.[8]

These statistics confirm why the insurance industry craves that insurance company fraud be addressed solely under state administrative procedures — little or nothing is likely to happen.

III. THE POWERFUL REMEDIES AVAILABLE UNDER RICO DO NOT IMPAIR STATE INSURANCE REGULATORY SCHEMES

The state insurance codes that RICO allegedly impairs do not provide for exclusive remedies for policyholders injured by insurance company unfair trade practices and fraud. They are merely one part of a system for addressing this important national problem.

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8. The attempts to give insurance regulators credit for initiating settlements to benefit Holocaust victims and the Prudential policyholders are misplaced. These matters were well underway before the insurance regulators first became involved.

A. The Structure Of The Model Act Indicates That It Is Primarily Designed To Protect The Public Against Insurance Company Charlatans.

Under Section 7 of the Model Act, an insurance commissioner initiates administrative action against a person that is engaged in any unfair method of competition or any unfair or deceptive act or practice. *Cf. United States v. Blumeyer*, 114 F.3d 758, 768 (8th Cir. 1997) ("our particular concern in *Doe* — that wronged policyholders would turn to RICO suits instead of pursuing administrative channels of relief, *see id.* at 1306-07 — is simply inapplicable here").

The commissioner serves a statement of charges on the insurance company and sets a hearing date. The insurance company then has an opportunity to show cause why an order requiring it to cease and desist from the unfair trade practice should not be entered. While no formal rules of pleading or evidence are required, the commissioner may administer oaths, examine and cross-examine witnesses, and receive oral and documentary evidence.

If the commissioner finds that the insurance company committed an unfair trade practice, then the commissioner may take action pursuant to Section 8 of the Model Act. The commissioner's action may include ordering the insurance company to cease and desist the unfair trade practice and to pay relatively minor monetary penalties. In addition, the commissioner may suspend or revoke the insurance company's license, if the violation was knowing. The commissioner may impose additional penalties if an errant insurance company violates a cease and desist order.

Absent from this administrative process is any right of an injured victim of insurance company fraud to initiate a proceeding, to participate in the hearing, or, most importantly, to recover any remedy. The victim may, like anyone else, intervene upon a showing of good cause. Model Act, Sec. 7(b). If the commissioner does not find an unfair trade practice, then an intervenor may appeal to a judicial forum. Model Act, Section 10.

The state administrative process is simply not designed to be the sole process to address insurance company unfair trade

practices and insurance company fraud. RICO civil damages do not impair the state insurance regulatory schemes, but supplement and support those systems. This should come as no surprise to the insurance industry. The insurance industry, including many of the Insurance Industry *Amici*, represented consistently to the NAIC that policyholders had substantial private remedies, including federal remedies, outside of the Insurance Department.

B. RICO Actually Assists State Insurance Departments To Combat Insurance Company Fraud

Contrary to the erroneous assumptions of the Petitioners, RICO actually assists, and does not impair, the states in their battles against insurance company fraud. Civil RICO is "designed to remedy economic injury by providing for the recovery of treble damages, costs, and attorneys' fees." *Agency Holding Corp. v. Malley-Duff & Assocs.*, 483 U.S. 143, 149-50 (1987); *see also, Shearson/Amer. Express, Inc. v. McMahon*, 482 U.S. 220, 240-41 (1987) (civil RICO treble-damages provisions are primarily remedial in purpose).

In a brief filed with this Court in 1995, the NAIC flatly contradicted the idea, urged by Petitioners here, that RICO impairs the enforcement of state insurance law:

> The National Association of Insurance Commissioners ("NAIC"), whose members are the principal state insurance regulators, strenuously disagrees with the notion that RICO impairs any state's insurance laws. The NAIC urges, to the contrary, that RICO enhances the effective enforcement of those laws.

Brief of *Amicus Curiae* National Association of Insurance Commissioners Supporting Respondent, *Prometheus Funding Corp. v. Merchants Home Delivery Serv., Inc.*, No. 95-409. Indeed, insurance commissioners routinely use RICO.[9]

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9. *See Kempe v. Monitor Intermediaries, Inc.*, 785 F.2d 1443 (9th Cir. 1986); *Schnact v. Brown*, 711 F.2d 1343 (7th Cir.), *cert. denied*, 464 U.S. 1002 (1983); *Kaiser v. Stewart*, Civil Action No. 96-6643, 1997 U.S. Dist. LEXIS 12788 (E.D. Pa. Aug. 19, 1997); *Clark v. Millam*, 847 F. Supp. 409 (S.D. W.Va. 1994); *State of North Carolina v. Alexander & Alexander Servs., Inc.*, 680 F. Supp. 746 (E.D. N.C. 1988).

A recent case from the Eastern District of Pennsylvania is illustrative. *See Kaiser v. Stewart*, Civil Action No. 96-6643, 1997 U.S. Dist. LEXIS 12788 (E.D. Pa. Aug. 19, 1997). The Insurance Commissioner of Pennsylvania brought a civil RICO action on behalf of an insolvent insurance company. The Commissioner alleged that the defendants had taken control of the insurance company, had siphoned off assets of the company, rendering it insolvent, and then had disguised that insolvency through a pattern of fraud.

The defendants in *Kaiser* argued that the McCarran-Ferguson Act barred the RICO claims. *Kaiser*, 1997 U.S. Dist. LEXIS 12788, at * 37. The district court rejected that argument, finding RICO to be consistent with the Pennsylvania insurance laws, regardless of the difference in remedies. *Id.*, at * 42-44. The court came to a similar conclusion in a parallel criminal RICO action, finding that the federal interest in protecting the public from racketeering is perfectly compatible with Pennsylvania's interest in protecting policyholders. *United States v. Stewart*, 955 F. Supp. 385 (E.D. Pa. 1997).

C. State Systems Allow Policyholders to Pursue Other Remedies, In Addition To Their Remedies Under State Unfair Trade Practices Acts

The Model Act and the state systems patterned after it allow policyholders to pursue private causes of action outside of the administrative procedure provided by the Model Act. The state unfair trade practices acts co-exist with other remedies under state common law, state non-insurance statutory law, and federal RICO.

1. The Nevada Scheme

The Nevada Unfair Trade Practices Act, particularly Nev. Rev. Stat. § 686A.310, which addresses unfair insurance trade practices, is not the exclusive remedy for policyholder damages caused by insurance company fraud. Section 686A.310 was patterned after the NAIC Model Act. *Hart v. Prudential Prop. & Cas. Ins. Co.*, 848 F. Supp. 900, 903 (D. Nev. 1994). It was added to the Nevada statutes in 1975 and sets forth twelve

specific activities that are deemed unfair trade practices. *See Tweet v. Webster*, 614 F. Supp. 1190, 1191 (D. Nev. 1985). The district court in *Tweet* held that Nev. Rev. Stat. § 686A.310 did not create a private cause of action for an injured third-party claimant. *Id.* at 1195.[10]

In response to *Tweet*, in 1987 the Nevada legislature amended § 686A.310 to eliminate the "frequency" or "general business practice" requirement and to provide specifically for a private cause of action:

> In addition to any rights or remedies available to the commissioner, an insurer is liable to the insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.

Nev. Rev. Stat. § 686A.310(2). This provision allows a policyholder to bring a judicial action to achieve redress for any activity proscribed in Nev.Rev.Stat. § 686A.310.

Moreover, Nevada common law provides a cause of action for an insurance company's tortious breach of the implied covenant of good fair and dealing. *See United States Fidelity & Guar. Co. v. Peterson*, 540 P.2d 1070, 1071 (Nev. 1975). A policyholder can obtain punitive damages for injuries caused by an insurance company's breach of the duty of good faith and fair dealing where the insurance company acted oppressively or where the insurance company has engaged in wilful and intentional conduct in reckless disregard of its possible consequences. *Ainsworth v. Combined Ins. Co. of Am.*, 763 P.2d 673 (Nev. 1988). Under Nev. Rev. Stat. § 42.010, a non-insurance statute of general application, a jury may award punitive damages where the defendant has been guilty of fraud, malice, or oppression. *Id.*, 763 P.2d at 675.

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10. One federal court subsequently held that the original version of Nev. Rev. Stat. § 686A.310 implied a private right of action by a first-party claimant, *i.e.* by the policyholder. *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1376-77 (D. Nev. 1989). *Amicus curiae* believes that this is the right result and that all state statutes based upon the Model Act provide for a private right of action in addition to preserving all non-insurance statutory and common law rights.

The insurance industry has argued that the treble damages imposed by RICO are more draconian than the Nevada statutory scheme and, therefore, somehow impair it. Common law punitive damages, however, can extend well beyond RICO's award of treble damages. In *Ainsworth*, the Nevada Supreme Court approved an award of $5,939,500 in punitive damages against an insurance company where the jury had found that the policyholders were entitled to $9,600 in benefits under the insurance policies, as well as an additional $200,000 in compensatory damages. RICO treble damages in *Ainsworth* would have amounted to a small fraction of the almost $6 million punitive damages awarded under state common law.

In addition, under Nevada's unfair trade practices act, the Insurance Commissioner can revoke or suspend an insurance company's license to do business, a remedy far more draconian than the imposition of treble damages.

2. The Illinois Scheme

Like Nevada, Illinois has adopted a state unfair trade practices act patterned upon the Model Act. Unfortunately, the courts in Illinois have held that there is no private right of action under the Illinois regulatory scheme. *See Anderson v. Humana, Inc.*, 820 F. Supp. 368, 373 (N.D. Ill. 1993), *aff'd*, 24 F.3d 889 (7th Cir. 1994). As is universally true in other states, however, the Illinois insurance regulatory scheme was never designed to occupy the field of private redress of insurance company fraud. Private remedies are not limited by the Illinois insurance regulatory scheme. *See Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371 (D. Nev. 1989). For instance, policyholders victimized by insurance company fraud may seek redress either under common law fraud doctrines or under non-insurance statutes such as the Illinois Consumer Fraud Act. *See Pinski v. Adelman*, No. 94 C 5783, 1995 U.S. Dist. LEXIS 16550, at * 20 (N.D. Ill. Nov. 2, 1995); *P.I.A. Michigan City, Inc. v. National Porges Radiator Corp.*, 789 F. Supp. 1421, 1426 (N.D. Ill. 1992). Policyholders bringing fraud actions in Illinois may be entitled to punitive damages and attorney's fees. *Gent v. Collinsville Volkswagen, Inc.*, 451 N.E.2d 1385, 1390-91 (Ill. App. Ct. 1983).

Common law and non-insurance statutory rights co-exist with the regulatory scheme. The fact that RICO provides for treble damages, 18 U.S.C.A. § 1964(c), no more impairs the insurance regulatory scheme than does the existence of common law fraud, punitive damages, or other non-insurance statutory causes of action available to the policyholder. *See NAACP v. American Family Mut. Ins. Co.*, 978 F.2d 287, 297 (7th Cir. 1992), *cert denied*, 508 U.S. 907 (1993); *Pinski*, 1995 U.S. Dist. LEXIS 16550, at * 20.

3. The Pennsylvania Scheme

The Third Circuit recently explained RICO's relationship with Pennsylvania statutory and common law. *See Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185, 192-95 (3d Cir. 1998). The court noted that, even though the insurance commissioner alone was empowered to enforce the Unfair Insurance Practices Act ("UIPA"), Pennsylvania courts had not barred common law suits for fraud and deceit arising out of insurance practices and had sanctioned policyholders' use of Pennsylvania's consumer protection statute to recover for insurance company fraud. *Id.* at 192. The Third Circuit found "no indication . . . that Pennsylvania's non-recognition of a private remedy under the UIPA represents a reasoned state policy of exclusive administrative enforcement or that the vindication of UIPA norms should be limited or rare." *Id.* at 195. Allowing the RICO action, the court ruled, would not "invalidate, impair or supersede" Pennsylvania's scheme of insurance regulation. *Id.*

D. RICO Criminal Remedies Are An Important Part Of The Web Of Laws Designed To Eradicate Insurance Company Fraud

The insurance industry is not immune from federal criminal statutes. If this Court decides that the McCarran-Ferguson Act precludes the application of civil RICO to insurance companies, it will jeopardize prosecutions under every federal criminal law enacted in the last fifty years.

On the contrary, a holding by this Court that civil RICO applies to the insurance industry will avoid the contortions

necessary to permit the continued enforcement of federal criminal laws. *See, e.g., United States v. Blumeyer*, 114 F.3d 758, 768 (8th Cir. 1997) (distinguishing criminal RICO from civil RICO on the basis that policyholders do not initiate administrative criminal action, ignoring the fact that policyholders do not initiate action under the unfair trade practices acts).

Some of the Insurance Industry *Amici* argue that the enactment of 18 U.S.C. § 1033, imposing criminal penalties for certain types of fraud committed by persons "engaged in the business of insurance," signals that Congress intended or understood that RICO would not apply to insurance companies.[11] If this dubious proposition were true, it would mean that the McCarran-Ferguson Act would exempt insurance companies and all persons engaged in the business of insurance from any liability under any general federal criminal statute passed since the 1945 enactment of the McCarran-Ferguson Act.

Thankfully, the proposition is not true. Section 1034(a), which imposes civil penalties for violations of Section 1033, provides that "[t]he imposition of a civil penalty under this subsection does not preclude any other criminal or civil statutory, common law, or administrative remedy, which is available by law to the United States or any other person." *See* 18 U.S.C. § 1034(a). Clearly, Congress understood that persons committing fraud while engaged in the business insurance could be held liable under other federal criminal and civil laws. RICO is just such a law.

IV. THE INSURANCE INDUSTRY CONSISTENTLY USES FEDERAL LAW AGAINST POLICYHOLDERS BUT DENOUNCES ITS USE TO REMEDY INSURANCE COMPANY FRAUD

A. The Insurance Industry Uses RICO Against Policyholders

The insurance industry's position on the application of federal law, particularly RICO, to the business of insurance

11. *See* Brief of Alliance of American Insurers, American Council of Life Insurance, Blue Cross and Blue Shield Association, Health Insurance Association of America, National Association of Independent Insurers, National Association of Mutual Insurance Companies and Reinsurance Association of America as *Amici Curiae* in Support of Petitioners, at 12 n.4.

swings like a weather vane in a tornado. The best illustration of the insurance industry's fleeting concern for principles of federalism is found in the insurance industry's own widespread use of RICO. When insurance companies claim to be victims of insurance fraud, they look to RICO for a remedy.

Aetna Casualty & Surety Company brought several actions against five automobile body shops and two insurance claim adjusters alleging that the parties engaged in a scheme to obtain payments under fraudulent insurance claims in violation of RICO. *See Aetna Cas. & Sur. Co. v. P&B Auto Body*, 43 F.3d 1546, 1551 (1st Cir. 1994). Aetna alleged that the parties committed predicate acts of mail fraud. *Id.* at 1560. Aetna brought the RICO causes of action at the same time it asserted that the defendants were liable to it under the Massachusetts Unfair Trade Practices Act, Mass. Gen. Laws ch. 93a, which allows for a private right of action, including the imposition of treble damages. *See id.* at 1566.

Insurance companies have brought many other RICO actions. *See, Preferred Mutual Ins. Co. v. Dumas*, Nos. 89-3394, 89-3446, 1991 U.S. App. LEXIS 21288 (6th Cir. 1991) (insurance companies brought a civil RICO action, as well as common law fraud actions, against a policyholder for the submission of fraudulent insurance claims); *State Farm Mut. Auto. Ins. Co. v. Ammann*, 828 F.2d 4 (9th Cir. 1987) (insurance companies sought RICO treble damages for the submission of false claims); *Vanliner Ins. Co. v. All Risk Serv., Ltd.*, 990 F. Supp. 1145, 1146-47 (E.D. Mo. 1997) (insurance company sought damages for, among other things, fraudulent inducement, negligent misrepresentation, breach of contract, breach of fiduciary duty, conversion, and violations of RICO relating to the issuance of certain insurance policies); *Nationwide Mut. Ins. Co. v. Perez*, No. 97-2172 (J.P.), 1997 U.S. Dist. LEXIS 13744 (D. P.R. 1997) (insurance company brought RICO action based on alleged insurance scam involving previously wrecked cars); *Soanes v. Empire Blue Cross/Blue Shield*, 970 F. Supp. 230, 239-241 (S.D. N.Y. 1997) (insurance company prevails in RICO claim in which defendants made representations to obtain low-cost insurance coverage for members); *Blue Cross of California v. SmithKline Beecham*, No. 397CV01795

AVC (D. Conn. filed Aug. 19, 1997) (thirty-five major health insurance companies charged SmithKline with RICO violations involving the alleged use of improper billing and kickbacks);[12] *Soanes v. Empire Blue Cross/Blue Shield*, 970 F. Supp. 230 (S.D. N.Y. 1997) (health insurance company brought RICO claims against administrators of various labor unions' health insurance programs); *Chubb & Son, Inc. v. Wigand*, N.Y.L.J., Jan. 23, 1998, at 26 (N.Y. Sup. Ct.) (insurance companies charged an insurance adjuster with violations of RICO for allegedly devising schemes to inflate insurance claims).

The insurance industry has also sought to benefit from pro-RICO decisions such as *Merchants Home Delivery Service, Inc. v. Reliance Group Holdings, Inc.*, 50 F.3d 1486 (9th Cir.), *cert. denied*, 516 U.S. 964 (1995) ("*Merchants Home*"). For instance, Zenith Insurance Company filed an action in federal district court alleging that the defendants had caused the filing of bogus insurance claims and had submitted fraudulently inflated bills for medical and other services in conjunction with those claims. *See Zenith Ins. Co. v. Eisenberg*, Nos. 94-55893, 95-56188, 94-56138, 1996 U.S. App. LEXIS 26815, at *6 (9th Cir. Oct. 11, 1996). Zenith Insurance Company brought both state law claims and federal RICO claims. *Id.* The district court dismissed Zenith's RICO claims under the McCarran-Ferguson Act. *Id.*

Zenith appealed and the 9th Circuit reversed and reinstated Zenith's RICO claims. *Id.* at *6-8. The Ninth Circuit held that the fraudulent practices of which Zenith complained were "prohibited both under California [state acts] and under the federal RICO statute." *Id.* at *8. The Ninth Circuit reasoned that "there is no principled basis for distinguishing, for McCarran-Ferguson Act purposes, between the alleged insurance [company] fraud in [*Merchants Home*] and the alleged insurance fraud in [*Zenith*]." *Id.*

12. The insurance companies in that case contended that they collectively represented "almost [forty percent] of America's private insurance industry." *See Health Insurers Sue SmithKline's Lab Division*, Ins. Coverage Litig. Rptr., Sept. 5, 1997, at 254; *see also, Insurers Sue Over Lab Billing*, Bus. Ins., Aug. 25, 1997, at 2.

One commentator has noted that insurance commissioners would go apoplectic if they suddenly found that they no longer could use RICO to prosecute allegations of insurance fraud. Christopher Winans, *Insurer's Weapon Against RICO Claims Could Backfire If It's Too Successful*, Best's Ins. Mgmt. Rep., June 14, 1993, at 4. One suspects that the insurance industry would be similarly apoplectic if it discovered that it could not longer use RICO or other federal statutes to combat insurance fraud when the insurance company is the victim and not, as here, the perpetrator.[13]

B. The Insurance Industry Uses Other Federal Laws Against Policyholders

Despite the picture portrayed in the various insurance industry briefs herein, the insurance industry is a "fair weather friend" of federalism. The insurance industry urges the application of federal statutes to the business of insurance whenever such application can enhance insurance company profits. One need look no further than the insurance industry's consistent use of the federal Employment Retirement Income Security Act, 29 U.S.C. 1001, *et seq.*, to trump otherwise troublesome state laws.

Insurance Industry *Amicus* ACLI is the largest life insurance trade association, and Insurance Industry *Amicus* HIAA purports to represent hundreds of companies that sell over eighty-five percent of America's health insurance. Brief of *Amici Curiae* for ACLI and HIAA in Support of the Petition,

13. The world has not, and will not, come to an end if the insurance industry is held subject to RICO. In *Barnett Bank v. Nelson*, the insurance industry argued to this Court that "the sky will come falling down," "eradicate the well-established state regulation" and undermine the regulatory scheme if the Supreme Court ruled that the McCarran-Ferguson Act did not preempt applicable federal law. *See* Petitioner's Reply Brief at Point II, *Barnett Bank v. Nelson*, 517 U.S. 25 (1996) (No. 94-1837) *quoting amici* briefs. The Court was not impressed with this parade of horribles. This Court held that the McCarran-Ferguson Act did not preempt the application of federal law. *Barnett Bank v. Nelson*, 517 U.S. 25 (1996). *See also, NAACP v. American Family Mut. Ins. Co.*, 978 F.2d 287, 297 (7th Cir. 1992), *cert. denied*, 508 U.S. 907 (1993) (insurance company unsuccessfully demanded exemption from the prohibition against redlining in the Federal Fair Housing Act).

Pilot Life Ins. Co. v. Dedeaux, No. 85-1043, Oct. Term, 1985 (dated Dec. 20, 1985) at 1 ("Pilot Life Brief"). In *Pilot Life*, ACLI and HIAA took a forceful anti-federalism position before this Court, arguing against the application of state common laws and in favor of the sole application of the federal ERISA statute. The ACLI and the HIAA wrote that "[t]he adjudication of benefit claims based upon diverse state common laws will inevitably result in the haphazard imposition of liability . . . ; . . . liability for compensatory and punitive damages is unpredictable under state common laws which permits such awards." *Id.*

Similarly, several years ago HIAA and ACLI joined a number of major insurance companies in arguing to this Court that, under ERISA, "state insurance regulations are not saved from preemption. . . ." Brief for Respondents The Travelers Ins. Co., et al., *New York State Conference of Blue Cross & Blue Shield Plans v. The Travelers Ins. Co.*, Nos. 93-1408, 93-1414 and 93- 415, 1993 U.S. Briefs 1408, Oct. Term, 1994 (dated Dec. 13, 1994).

Other examples of insurance industry attacks on federalism abound. A recent AIA press release began with the following observation:

> Fifty state regulatory systems can be redundant and costly for the nation's property and casualty insurers, particularly at the time when competition is intense and companies are slashing business costs.

AIA, *AIA Continues Assault on Regulatory Red Tape* at 1 (June 16, 1998).[14] One of the AIA's goals is to free commercial insurance from price regulation by state insurance regulators. *Id.*

The insurance industry regularly champions federal legislation that protects it from having to pay claims arising out of state-based consumer litigation. On August 13, 1998, the AIA championed federal legislation relieving companies with Year 2000 liability from some lawsuits. *See* AIA, *News* (Aug. 13, 1998).[15] Applauding the legislation, the AIA opined that Congress needed to do more to limit liability. *Id.*

14. This document is publicly available on the Internet at www.aiadc.org/press/061698.html.

The AIA recently supported federal legislation in the area of highway safety, stressing the financial impact of motor vehicle accidents upon "auto insurance consumers." AIA, *Insurers Urge President to Sign Highway Funding Measure* (June 3, 1998).[16] A number of years ago, State Farm Insurance Company and a group of insurance companies successfully forced the United States Department of Transportation to impose mandatory automatic restraint standards upon the automobile industry. Insurance Information Institute, III *Insurance Issues Update* (Sept. 1998) at 7.[17]

Within the past month, Insurance Industry *Amicus* HIAA applauded the involvement of the federal Health Care Financing Administration ("HCFA") in helping insurance companies to combat insurance fraud and abuse. HIAA termed insurance fraud a "very important national issue." Statement of Chip Kahn, CEO and President-Designee, HIAA at 1.[18] An HIAA publication noted that the HIAA "offers representation before Congress and other bodies to influence federal legislation and regulation" and drafts federal "legislation, amendments, floor statements, and testimony." HIAA, *About HIAA* at 1.[19]

The HIAA similarly lauded the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

> Federal laws affecting health care and the health insurance marketplace ensure a certain degree of regulatory uniformity for consumers, particularly multi-state employers. HIAA believes that responsible federal

15. This document is publicly available on the Internet at www.aiadc.org/press/081398.htm.

16. This document is publicly available on the Internet at www.aiadc.org/press/060398.html.

17. This document is available on LEXIS.

18. This document is publicly available on the Internet at www.hiaa.org/newsroom/press-releases/release2.html.

19. This document is publicly available on the Internet at www.hiaa.org/abouthiaa/purpose.html.

reform can assure a stable, affordable, and responsive health care system that lasts well into the next century.

HIAA, *Federal Perspectives* (July 31, 1997) at 1.[20]

The HIAA also called for federal involvement in controlling health care litigation: "HIAA supports federal legislation that would impose limits on punitive damage awards and on joint and several liability for non-economic damages. *Id.* at 4. "HIAA also supports federal legislation to limit extra-contractual and punitive damages both for health care claims disputes and for malpractice and other medical liability awards." *Id.* The HIAA even championed federal insurance consumer protection standards in HIPAA, noting "nothing in the new law prevents states from imposing more stringent consumer standards." *Id.* at 7. Apparently, HIAA would not take the position that those more stringent state standards would impair the federal standards.

In a statement to Congress, the Reinsurance Association of America ("RAA") noted that "federal involvement is a necessary component" to address the issue of "natural catastrophe exposure and insurance." Statement of Franklin W. Nutter, Pres., RAA Before the U.S. House of Representatives Committee on Banking and Financial Services (Apr. 23, 1998) at 1.[21] The RAA stressed that "[t]he reinsurance industry has maintained a consistent position on the need for high-level federal involvement in excess private market capacity." *Id.* at 1. The RAA further testified that "[s]tate catastrophe funds should only be employed as a last resort." *Id.* Indeed, the RAA criticized one bill, H.R. 219, because it "**will encourage the greater intrusion of state government into the private insurance market ....**" *Id.* at 6 (emphasis in original). Insurance Industry *Amicus* NAII also strongly supported federal disaster relief legislation. "NAII Member Urges Congress to Strengthen Disaster Bill," PR Newswire Assoc., Inc. (Apr. 23, 1998) at 1.[22]

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20. This document is publicly available on the Internet at www.hiaa.org/consumerinfo/fedpers2.html.

21. This document is publicly available on the Internet at www.raanet.org/policy/testimony/fwntestimony_42398.html.

22. This document is publicly available on LEXIS.

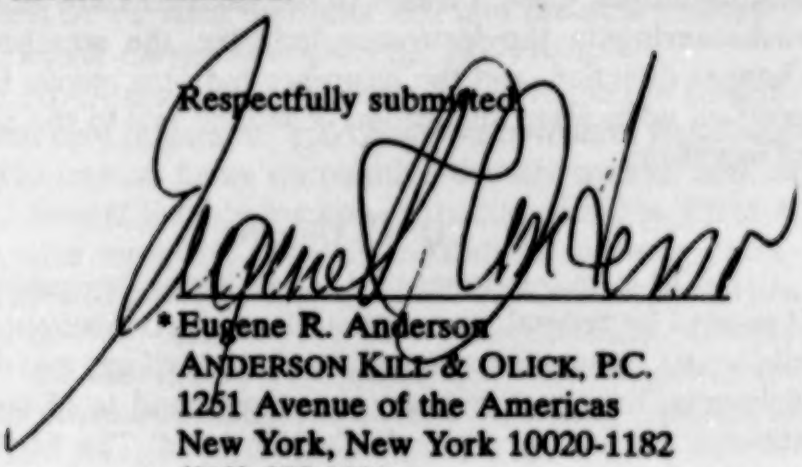
Although the insurance industry has supported these federal initiatives, when it comes to federal legislation combating racketeering in the insurance industry, the weather vane changes direction, and the insurance industry recoils from its position advocating application of federal law to the business of insurance.

CONCLUSION

RICO is an important tool in combating insurance fraud. It is used by federal prosecutors, the nation's insurance commissioners, insurance companies, policyholders, and injured claimants. Insurance industry company fraud is of no lesser national concern than is policyholder fraud. The Model Act and the various state insurance codes do not comprehensively or exclusively attempt to regulate private remedies for policyholders. Instead, the Model Act and the insurance codes expressly provide that, in addition to any regulatory remedies or penalties, insurance companies will remain liable under any other applicable non-insurance statute or common law. In large part, this feature of the state insurance regulatory system is a direct result of the insurance industry's strenous efforts to avoid having the nation's insurance commissioners exercise comprehensive control, let alone exclusive control, over private remedies for insurance company fraud. For these reasons, RICO does not "invalidate, impair or supersede" the Nevada Insurance Code or other state insurance codes.

For the reasons set forth herein, the Court of Appeals' opinion should be affirmed.

Respectfully submitted,



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